



## DOCTORAL THESIS

### **Psychodynamic psychotherapists' lived experience of working with patients with borderline personality disorder An interpretative phenomenological analysis**

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*Award date:*  
2012

*Awarding institution:*  
University of Roehampton

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**Psychodynamic psychotherapists' lived  
experience of working with patients with  
borderline personality disorder: An  
interpretative phenomenological analysis**

by

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*A thesis submitted in partial fulfilment of the requirements for the degree  
of PsychD in Counselling Psychology*

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**2012**

## Acknowledgements

My gratitude to all the five psychotherapists who participated in this research study, I am grateful that they dedicated their time to share their experiences with me and were so open and honest in their interviews. Without them, this study could not have been carried out. These people are not named so that the confidentiality and anonymity of participants is preserved.

Thank you also to both members of my supervisory team, Dr Lyndsey Moon & Dr Steve Farnfield.

Finally, thank you to all my friends and family, mainly to my wonderful partner, Klaus, who encouraged and supported me during the completion of this study.

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## Abstract

This thesis presents an in-depth exploration of psychotherapists' lived experience of working with borderline personality (BPD) disorder in psychodynamic<sup>1</sup> psychotherapy, using interpretative phenomenological analysis (IPA). The existing research literature suggests that working with borderline patients<sup>2</sup> is very difficult, as they can evoke negative countertransference experiences in therapists and thus make the working alliance difficult to maintain. The stigmatising and negative attitude towards BPD, which is found amongst mental health professionals, can cause many therapists to avoid working with this patient population, leaving many patients without the necessary help for treatment. Some literature also suggests that psychodynamic therapy may not be helpful for the treatment of BPD in its traditional form, because of the neutrality of the model and borderline patients' 'reduced capacity to mentalise'. Instead, empathy and the therapeutic relationship have been reported to be significant factors. This qualitative study aimed to provide a rich and detailed examination of the experiences, which psychodynamic psychotherapists and counselling psychologists might have in their work with BPD patients. Five psychodynamic psychotherapists were interviewed twice in one unstructured and one semi-structured interview, and IPA was used to analyse the data. The five master-themes (Negative countertransference feelings; "Sitting in the dark together"; Hindrance in therapeutic work; Therapist omnipotence; Labelling as problematic) found in this study suggested that borderline patients could benefit from a modified version of psychodynamic

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<sup>1</sup> Note that the 'psychodynamic' and 'psychoanalytic' terms will be interchangeably used in this study.

<sup>2</sup> The researcher, as a trainee-counselling psychologist, is in favour of using the word 'client'. However, psychodynamic practitioners talk about their 'patients' rather than 'clients', and as this study focuses on psychodynamic therapists' experiences, the researcher will use these two terms interchangeably. Thus, the word 'patient' here is applied in the psychodynamic and not in the medical sense.

psychotherapy with a focus on empathy and a bond between therapist and patient. Furthermore, the therapists' awareness of negative countertransference feelings and emergent obstacles in the therapeutic work, as well as their understanding of BPD as a label and its effects on their borderline patients were crucial. Finally, the therapists' experienced 'omnipotent' feelings, which may have emerged in response to their negative countertransference feelings. While these findings support many of the previous publications and accounts reported in the literature, they also shed new light on therapists' experiences, which might have implications for the approach that psychotherapists and counselling psychologists take towards working with borderline individuals within the psychodynamic modality.

## Chapter One: Introduction and Research literature review

### 1:1 Introduction

#### *1:1.1 Reasons for undertaking this study*

This research study investigates therapist experience of working with borderline personality disorder (BPD) in psychodynamic psychotherapy. The interest in this phenomenon was generated by the researcher's awareness, as a trainee counselling psychologists, of a growing body of negative literature about psychodynamic psychotherapists' difficulty in working with BPD (e.g. Binks *et al.*, 2009). This difficulty has mainly been related to therapists' experience of hostile counter-transference feelings, due to the nature of the disorder and patients' difficulty in handling the psychodynamic modality. However, evidence mainly comes from quantitative measure outcomes. The researcher intended to explore therapist experience of working with this patient population using a qualitative methodology, which fits well with the philosophies and ethos of counselling psychology. Thus, this study chose its topic for a purpose.

### 1:2 Research literature review

#### *1:2.1 The definition, causes and treatment for Borderline Personality Disorder*

##### *1:2.1. i What is Borderline Personality Disorder?*

Borderline personality disorder (BPD) is a Cluster B (Axis II) personality disorder mainly characterized by marked impulsivity, instability of mood and interpersonal relationships, feelings of emptiness and boredom, and self-harm

and suicidal behaviour, which can make medical care difficult (Paris, 2005). Thus, most mental health professionals find this chronic psychiatric disorder, which is frequently seen in clinical practice, quite challenging to work with (Binks *et al.*, 2009). Usually a GP or psychiatrist would make a diagnosis. However, as the 'borderline' term originally stems from psychoanalytic thinking, psychodynamic psychotherapists may apply the term to patients, despite their lack of medical training (NAMI, 2006).

In the 19<sup>th</sup> century, Kraepelin identified cases of 'borderland' schizophrenia and recognised that mental states existed between normality and insanity (Dawson and McMillan, 1993). However, two major psychoanalytic views of Freud and his followers overshadowed Kraepelin's 'symptom pattern' view of BPD. Some of these psychoanalytic writers believed that BPD was a type of schizophrenia ('pseudoneurotic schizophrenia'), whereas others argued that it was between neurosis and psychosis (Dawson and McMillan, 1993). The actual term "Borderline Personality Disorder" dates back to the early 1900s, when people with mental health disabilities were categorized as either neurotic or psychotic. Dr. Stern (1938), an early psychiatrist, realized that a growing body of patients did not fit into either of these categories and coined the term "borderline", a combination of neuroses and psychoses. Later psychoanalytic thinkers, such as Kernberg (1967), defined the condition as distinct from schizophrenia. In the 1970s, Grinker and Gunderson classified common characteristics in BPD and established a series of criteria to identify the condition. These contributed to the formulation of the criteria for the diagnosis of

BPD, which are seen in the DSM III, and its subsequent editions today (Mayes and Horwitz, 2005).

The DSM-IV lists nine discrete features and requires five of these to be present over six months of time before the diagnosis of BPD can be made. These are: Frantic efforts to avoid real or imagined abandonment.; A pattern of unstable and intense personal relationships; Identity disturbance; Impulsivity in at least two areas that are potentially self damaging; Recurrent suicidal behaviour, gestures, threats or self-mutilating behaviour; Affective instability due to a marked reactivity of mood; Chronic feelings of emptiness; Inappropriate, intense anger; Transient, stress related paranoid ideation or severe dissociative symptoms. The European version, the International Classification of Diseases (ICD-10; WHO, 1992) is largely in agreement with these criteria although less comprehensive in its description of BPD. However, the ICD classifies the condition under the name of Emotionally Unstable Personality Disorder (F60.3) of which there is an impulsive type (F60.30) and a borderline type (F60.31) (ICD-10, 1992). The latter majorly overlaps with the DSM-IV definition of BPD (Binks et al., 2009). However, while two people can meet the same operational criteria of the disorder, they might have two completely different personalities, a phenomenon which can lead to a fundamental problem in the polythetic definition of BPD (Binks *et al.*, 2009).

The prevalence of BPD is about 1% with about 80% of patients being female. It is estimated that 10% of outpatients and 20% of inpatients who need treatment for the above described symptoms and difficulties have BPD. Since

many of these symptoms are characteristic of other disorders, such as mood, anxiety, substance or eating disorders (Zanarini *et al.*, 1998), the diagnosis of BPD may go undetected. However, BPD rarely stands alone. There is high co-occurrence with other disorders, such as major depressive disorder, substance abuse, antisocial and narcissistic personality disorders (NAMI, 2006). Many BPD patients meet the criteria for histrionic, narcissistic or antisocial personality disorder (Stone, 2006). For there is also a high comorbidity with depression, due to intense mood swings, BPD is often mistaken for bipolar disorder (Paris, 2004). Furthermore, because of quasi-psychotic thoughts and episodes, BPD can be mistaken for schizophrenia (Zanarini, 1990).

Approximately 75% of patients self-injure, 60%–70% of patients make suicide attempts (Gunderson *et al.*, 2007) and about 1 in 10 patients eventually commit suicide (Paris and Zweig- Frank, 2001). However, 90% of patients can get better in spite of making threats to end their lives on many occasions. The process of recovery in BPD is not fully understood, but impulsivity generally decreases with age, and patients learn over time how to avoid the most distressing situations, such as intense love affairs, in order to find the stability they need (Paris, 2003). About 75% of patients with BPD will reach close to normal functioning by the age of 35 to 40 years, and 90% will recover by the age of 50 (Paris and Zweig-Frank, 2001). Relapses are about 10% over 6 years, as opposed to several Axis I disorders, where improvement is more rapid, but recurrence occurs more often (Fonagy and Bateman, 2006b).

### *1:2.1. ii Causes: Biological, psychological and social*

Both researchers and clinicians have been trying to understand the cause of borderline personality disorder for years. While there are authors who believe that borderline personality disorder is a type of affective disorder (Coid, 1993), other clinicians argue that the combination of severe trauma and dissociative phenomena in BPD is closely related to post-traumatic stress disorder (Winston, 2000). Stone (1980) advocated that some borderline patients developed their personality disorder, due to an underlying mood disorder, mainly of a recurrent depressive or a bipolar II type. Although, this view is not supported by other authors (Stone, 2006). It is generally believed that a combination of biological, psychological and social factors all play a role. Biological factors in personality disorders contain temperamental characteristics, which demonstrate unstable personality traits in adulthood (Rutter, 1987). Twin studies have shown that there is a strong genetic influence in the development of BPD (Torgersen *et al.*, 2000). For instance, affective instability (Livesley *et al.*, 1998) and impulsivity (Hinshaw, 2003), have been found to be heritable components. The combination of affective instability with impulsivity is believed to contribute to chronic suicidality and instability of interpersonal relationships (Siever *et al.*, 2002). However, the biological correlates of affective instability are not yet known and no specific explanation to the overall disorder has been provided (Gurvits *et al.*, 2000).

Psychological factors, which seem to contribute to the development of borderline personality disorder, include adverse and traumatic events. Childhood

abuse and neglect are particularly common among this patient population. A quarter of patients report sexual abuse from a caretaker (Zanarini, 2000; Herman *et al.*, 1989) and about a third recall severe forms of abuse (Paris *et al.*, 1994). Evidence comes from research studies, which have reported that up to 87% of patients have suffered some form of childhood trauma, 40–71% has been sexually abused and 25–71% has been physically abused (Perry and Herman, 1993). The effect of abuse is thought to depend on the stage of psychological development at which it takes place. It seems that the earlier it takes place, the more damaging it is likely to be (van der Kolk *et al.*, 1994), due to the young child's cognitive immaturity and inability to make sense of adverse experiences. As a result, individuals with borderline personality disorder are prone to experience others as malevolent, to experience relationships in need-gratifying ways, and to be especially sensitive to abandonment (Westen, 1990).

Regarding the social factors, recently a few social theoretical explanations of identity disturbances in BPD have been proposed by researchers. Paris (1996) believes that personality disorders stem from an association between biologically determined temperament or personality traits and the social structures within which a person lives. In traditional societies, personality disorders may occur because of ‘overcontrol’ in relation to certain social norms and social conventions. Therefore, those individuals who seek autonomy and self-definition find themselves inconsistent with these social conditions. Thus, the feelings of undercontrol can generate instability, impulsivity and an unstable sense of identity in individuals, characteristic of borderline personality disorder. Similarly, Jorgensen (2006) argues that in society social structures have



deteriorated whereby social rules and conventions are being imposed upon its individual members. Consequently, people have failed to develop a sense of identity, leading to personality disturbances and psychopathologies, such as BPD.

*1:2.1. iii Medication as a treatment option for Borderline Personality Disorder*

The two main categories of treatment for BPD are pharmacology, including a range of medication options, and psychotherapeutic techniques, both individual and group, incorporating supportive counselling and psychoanalysis (Cowdry and Gardner, 1988). Pharmacological treatments include atypical antipsychotic agents, SSRIs to treat the deficiencies in serotonin absorption and neuroleptics to treat psychotic symptoms and dysphoria. Carbamazepine has been used in the treatment of behavioural and affective problems (Cowdry and Gardner, 1988). Medications have been shown to be very helpful in reducing the severity of symptoms and in treating those disorders, which commonly co-occur with BPD, and allowing effective psychotherapy to occur (NAMI, 2006). Psychopharmacological treatment, educational and support groups are often used alongside psychotherapy to help control symptoms, such as cognitive-perceptual, affect dysregulation, or impulsive and behavioural dyscontrol (Stone, 2006). Patients with BPD can be hospitalised to deal with crisis management, such as when the individual's safety is at risk, following an episode of self-harm or suicidal attempt. However, hospitalisations are usually short in duration (NAMI, 2006).

*1:2.1. iv The view of 'psychopathology' and 'diagnosis' from a counselling psychologist's perspective*

In the debate about 'psychopathology' and the use of diagnostic categories, related to counselling psychology's position, there is a tension between its humanistic philosophy, which focuses on understanding the client's unique and subjective experiences within an interactional system, and the medical model, which 'reduces' human experience to diagnostic categories using taxonomic systems such as the DSM-IV (American Psychiatric Association, 1994) and ICD-10 (World Health Organisation, 1992). This latter positivist-empiricist view has dominated the scientific and psychotherapeutic world in an attempt to diagnose 'objectively' different types of 'disorders' that fall under the concept of 'psychopathology' (Fee, 2000). This tension is further emphasised by counselling psychology's commitment to the scientific-practitioner model on the one hand, and the recognition that 'psychopathology' is constructed within a social, cultural, economic and historical context on the other (Golsworthy, 2004).

Thus, counselling psychology has adopted a postmodern approach. This accounts for the relationship between theory and practice, as well as for the dilemma between psychological theories inherent in modernism and professional practice which emphasises the non-pathologizing account of psychological distress and the uniqueness and subjectivity of each individual (Polkinghorne, 1992; Rizq, 2008). There is, therefore, an awareness of this inevitable tension which exists throughout this thesis. On the one hand, the researcher, as a trainee counselling psychologist, uses diagnostic language, such as 'BPD' and 'borderline patients', as opposed to 'clients', which is rooted in counselling

psychology<sup>3</sup>, in an attempt to describe and understand what the condition called BPD is and how it may be treated. On the other hand, there is a focus on those texts in the literature which describe psychotherapists' prejudice towards patients with this diagnosis and the stigmatising effect of labelling these individuals with BPD.

### 1:2.2 Borderline Personality Disorder and Psychotherapy

#### 1:2.2. i Different psychotherapy treatments for Borderline Personality Disorder

In the past, psychiatrists tended to believe that personality disorders were not manageable and that they could not be effectively treated. However, today the most effective treatment for BPD is believed to be psychotherapy. There are three major psychotherapeutic models in the treatment of this disorder: psychodynamic (or psychoanalytic), cognitive-behavioural and supportive therapy with special varieties within each (Stone, 2006). For instance, mentalisation-based treatment (MBT; Fonagy and Bateman, 2005) and transference-focused psychotherapy (TFP; Kernberg, 1975) are different forms of psychodynamic therapy, and dialectical behavioural therapy (DBT; Linehan, 1993) is a form of cognitive-behavioural therapy. Today, the most beneficial form of therapy for the treatment of BPD is DBT, which has been shown to be effective in the management of certain self-destructive behaviour in borderline patients, such as bringing suicidal and impulsive behaviours under control within a year (Linehan *et al.*, 1991).

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<sup>3</sup> Although here the researcher, as a trainee counselling psychologist, talked about the diagnosis of 'BPD' in a medical fashion, this was in an attempt to be consistent with the existing research literature and the participants' narratives in the study, as well as to be transparent to the reader.

DBT targets affective instability and impulsivity, through group and individual sessions, and teaches patients behavioural skills training of mindfulness, interpersonal effectiveness, distress tolerance and how to regulate their emotions (Linehan, 1993). However, long-term effects are rather disappointing, as general improvement is maintained only at six months but not at a one-year follow-up, and the drop out rate is 16% (Meares *et al*, 1999). Furthermore, it does not emphasise the importance of the working relationship in therapy, to help borderline patients with their interpersonal relationship problems. Thus, this type of solution-focused therapy often neglects the core problem of people who suffer from this disorder (Grohol, 2007). Most importantly, there is an ignorance of patients' difficulty in expressing appropriate emotions and emotional attachments to significant others in their lives, due to the main emphasis being on faulty cognitions (Grohol, 2007).

Supportive psychodynamic psychotherapy is another type of treatment, where techniques such as listening, education, encouragement, limit setting, exhortation (to do or to refrain from certain behaviours), reassurance, advice, and validation are the main hallmarks of focus (Rockland, 1989). While these techniques treat more the human being than the symptoms, in a study by Clarkin and his colleagues (2007), supportive treatment alone was found to be only predictive of change in impulsivity, whereas TFP and DBT were found to be more effective than general supportive therapy. On the other hand, when supportive therapy was part of other treatment modalities, such as DBT, there was a significant improvement in depression, anxiety, global functioning, and social adjustment. While transference feelings are recognized in the supportive approaches, transference interpretations are not used.

However, Stone (2006) argues that therapy should not merely focus on diminishing the self-damaging acts and other symptoms, such as, depression, eating and other personality or mood disorders alone, but should also aim at improvement in the borderline patient's ability to function at work, establish and maintain friendships and intimate relationships. In order to achieve these goals, there is a need for long-term ongoing psychotherapy. Consequently, there have been advances in understanding the condition and the development of psychosocial interventions. These advances are emphasised by the third type of therapeutic treatment for BPD, psychodynamic psychotherapy (Stone, 2006). The psychodynamic model promotes psychic integration with a focus on transference, counter-transference, defences and projective identification (Stones, 2006).

According to Gunderson (2001), borderline patients in psychodynamic psychotherapy need to be able to control their impulses, be introspective, psychologically minded, and motivated to change. Despite this, the dropout rate is still high. Yet, psychodynamic psychotherapy is believed to be prominent in the treatment of borderline personality disorder, which is supported by both the APA Practical Guidelines (Oldham et al., 2001) and research evidence. For instance, Leichsenring and Leibing (2003) reviewed 14 studies of different forms of psychodynamic therapy (e.g. manualised supportive-expressive, object-relations, self-psychological, interpersonal, MBT and brief psychodynamic therapy) and 11 studies of cognitive behavioural therapy (e.g. DBT)), published between 1974 and 2001, which included patients with Axis I comorbidity of personality disorders, such as BPD. The data showed longer-term changes in psychodynamic therapy (76 weeks) than in CBT (13 weeks). Moreover,

significant results were found for all measures of personality disorder with the mean recovery rate of 59%, despite previous reports that borderline patients with comorbidity do badly in psychodynamic psychotherapy (Wallerstein, 1986).

The study of Stevenson & Meares (1992/1999) was also included in the above described meta-analysis. They used a specialised form of brief psychodynamic psychotherapy, based on Kohut's self psychology (1980), Winnicott's developmental approach (1961) and the work of Robert Hobson (1985), with an interpersonal and collaborative focus, in order to meet the needs of borderline patients. Stevenson & Meares (1992/1999) reported that 48 borderline patients treated twice a week for a year had significant improvements in a number of episodes of self-harm, violence, length of hospital admissions and other factors, while 30% of them no longer met the criteria for borderline personality disorder. These changes were maintained at a one-year and a five-year follow-up, as opposed to Linehan's study (Linehan *et al.*, 1993), in which improvement was maintained at six months but not a one-year follow-up (Meares *et al.*, 1999).

#### *1:2.2. ii The traditional psychodynamic versus the different types of psychodynamic psychotherapy treatments for Borderline Personality Disorder*

The general view in the literature seems to be that, due to the difficulty of a patient with severe personality disorder in handling transference interpretations, the traditional psychodynamic approach might be a high-risk intervention (Gabbard *et al.*, 1988). The classical psychoanalytic theory emphasises the individual's earliest relationships and their pathologies, and views transference as a re-creation of past relationships, where working through

the transference is the primary process, which helps clients to re-experience and then move away from their infantile fixations (Freud, 1912). Gunderson *et al.* (2007) suggest that all types of psychodynamic approaches should recognize that effective work with borderline clients requires comprehensive modifications from the technical neutrality and lack of structure that characterize traditional psychoanalytic therapy. This claim is supported by an extensive literature on psychoanalytic treatments for borderline personality disorder, in which an inadequate therapeutic structure, hostile counter-transferences, and a failure to be an active participant in here-and-now interactions led to rages, suicidal threats or gestures, therapeutic regressions, non-compliance, excessive intersession demands, and frequent dropouts (e.g. Gunderson *et al.*, 2007). Thus, Waldinger and Gunderson (1984) suggest that only a minority of borderline patients improve from psychoanalytic psychotherapy in its traditional form.

While unconscious forces and conflicts may be responsible for borderline clients' highly polarised attitudes, mood swings and outrageous behaviours, these behavioural patterns are likely to be triggered in their interpersonal relationships and thus in their relationships with the therapist (Stone, 2006). Accounts in the research literature suggest that when a borderline patient feels in danger of the potential loss of the supportive and holding relationship, involving a person or institution, then manipulative and self-destructive acts are not uncommon (Gunderson, 1997). According to Dozier and Tyrrell (1998), the secure environment and attachment provided by the therapist enhances the work, in order to change maladaptive working models in BPD, while Wallerstein (1986) proposes that supportive, attachment-generating and empathic interventions are vital in modern psychoanalytic therapy. Thus, one of

the most effective modified types of psychodynamic psychotherapy for BPD is Bateman and Fonagy's (2004a) mentalisation-based treatment (MBT), which is a combination of cognitive, psychoanalytic and attachment theories.

Fonagy and Bateman (2006a) contend that the effectiveness of traditional psychodynamic approaches depend on the capacity of the individual to integrate the experience of their own mental state with the alternative perspective offered by the therapist. This depends on 'mentalisation', a process in which the individual implicitly or explicitly makes sense of themselves and others as meaningful on the basis of their subjective mental states (Bateman and Fonagy, 2010). However, borderline clients may find it impossible or very difficult to recognise what effects their behaviour has on other people and to 'put themselves in other people's shoes' and empathise with others. This is known as 'reduced mentalisation' (Fonagy and Bateman, 2006a). In therapy, the difference between the patient's inner experience and the perspective given by the therapist, in the context of feelings of attachment to the therapist, can lead to instability in the patient. On the basis of their history and biological predisposition, it is believed that people with BPD have hyperactive attachment systems, which may account for their reduced capacity to mentalise (Fonagy and Bateman, 2006a). Recent neuroscientific findings have provided evidence that attachment and mentalisation are closely linked psychological systems, as activation of the attachment system is likely to inhibit temporarily the normal adult's ability to mentalise (Bartels and Zeki, 2004). Thus, people with reduced capacity to mentalise are unlikely to benefit from traditional psychological therapies.



Thus, it seems that clients are especially vulnerable to the side effects of psychodynamic treatments, which activate the attachment system, leading to behavioural and psychological disturbances and to iatrogenic harms, such as self-harm and suicide. Yet, without the activation of the attachment system, it is very challenging for borderline individuals to acquire a capacity to develop psychologically in the context of interpersonal relationships, which is one of their fundamental problems (Fonagy and Bateman, 2006a). The goal of MBT, therefore, is to stabilise the sense of self, to help the patient read the mental states of self and others more accurately, to better regulate emotions, with regard to the external world, and to maintain an optimal level of arousal within a well-managed, but not too intense, not too detached, attachment relationship between therapist and patient (Bateman and Fonagy, 2010). It is argued that in MBT, just as in the traditional psychodynamic modality, the patient will not understand much of the transference interpretations that the therapist provides to them in relational terms, due to their levels of mentalising capacity (Bateman and Fonagy, 2010). Thus, the rigid experience of the self and the therapist may cause relationship implications, while interpretations made too early can lead to destabilization (Bateman and Fonagy, 2004a). However, randomized controlled trials have shown the effectiveness of an 18-month MBT treatment in an outpatient setting, where patients with BPD showed a decrease in both self-reported and clinically significant problems, including suicidal attempts and hospitalisation (Bateman and Fonagy, 2009).

The other type of modified psychodynamic psychotherapy for BPD is transference-based psychotherapy (TFP) developed by Kernberg *et al.* (2002). The assumption is that due to a lack of integration of the concept of self and of

significant others, resulting from the predominance of aggressive internalised object relations, the patient's ego is fixated at the level of primitive defence mechanisms to protect the idealised self and object representations. Therefore, the goal of treatment is to help the patient decrease the use of primitive defences and develop better self-control through the integration of the split-off representations of self and others, which are triggered, observed and interpreted in the transference relationship (Clarkin *et al.*, 2007). Although, TFP therapists talk to the patient about the relational aspects of the transference, they do so only at the very beginning of treatment (Bateman and Fonagy, 2004a). Similar to the traditional psychoanalytic model, TFP suggests that the use of supportive interventions endangers the transference and counter-transference paradigm. Hence, it is based on clarification, confrontation, limit setting and interpretation (Kernberg *et al.*, 2002). The purpose of interpretations in TFP is to confront the patient and clarify what is in their mind. This is in contrast with MBT where the therapist takes the stance of 'not knowing' the patient's mind better than the patient knows it himself. However, both TFP and MBT value the interaction in the here-and-now, as well as the role of the therapist, unlike the traditional psychodynamic model, which mainly focuses on the patient's early relationships and developmental experiences.

The therapist's counter-transference feelings<sup>4</sup> in TFP are significant, as they are believed to provide the therapist with the most significant account of the patient's troubled life and underlying difficulties. Thus, Kernberg *et al.* (2008)

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<sup>4</sup> The definition of the concept of counter-transference is discussed in section 1:2.3.ii, on page 26.

argue that patients with severe character disorders, such as those with borderline and psychotic levels of organisation, benefit from TFP, due to the process of transference in which patients generate counter-transference feelings in the therapist. There is research evidence for the effectiveness of TFP in comparison with other types of treatment for BPD. For instance, Clarkin *et al.* (2007) evaluated three different types of treatment for BPD (DBT, TFP and dynamic supportive therapy) with a focus on positive changes in twelve variables assessed across six areas: suicidal behaviour, aggression, impulsivity, anxiety, depression and social adjustment. While TFP showed a positive change in 10 of the 12 variables, DBT was successful only in 5 of the 12, and supportive therapy in 6 of the 12. While both TFP and DBT indicated a decrease in suicidality, only TFP and the supportive treatment had a significant improvement in anger management, impulsivity, irritability and verbal assault. However, one limitation of the study was that patients in the TFP group received more individual psychotherapy sessions than those in the DBT group. Thus, it might be that the improvements in the TFP group were partly affected by the number of sessions given to patients rather than by the type of treatment alone.

### *1:2.2. iii Obstacles in working with BPD in psychodynamic psychotherapy*

In the literature it has been reported that while borderline individuals are often in crisis, they are difficult to engage in any type of treatment. As the complex symptoms of BPD often make patients difficult to treat, feelings of anger and frustration may be evoked in health professionals who try to help. Consequently, many professionals are often unwilling to make the diagnosis or

treat persons with these symptoms (Gunderson, 2001). Therapists can feel frustrated, anxious and resentful, due to these individual's challenging behaviour and ambivalence about treatment, which can all easily lead to therapeutic nihilism (Winston, 2000). Although, psychotherapy is believed to be the most effective treatment for BPD, Goldstein (1996) suggests that there are strengths and weaknesses of working with borderline patients in psychotherapy.

The strength is that the borderline patient often seems to do well in interpersonal relations. On the surface, the patient seems to "relate" to others, can have many acquaintances and sometimes can maintain long-term relationships. However, weaknesses emerge when it becomes clear that the relationship is characterized by a major lack of depth and concern for the other individual (Goldstein, 1996). The other person is seen as someone who can be used to meet the borderline patient's needs rather than as a person in his or her own right. When there is no empathy in the relationship between the borderline individual and the significant other, the borderline person often vacillates between superficial relationships and intense, dependent relationships that are marked by primitive defences. Thus, the weakness can surface under stress and in very close interpersonal situations where there is a tendency for the ego function to regress, and lead to brief and short-lived psychotic episodes (Goldstein, 1996).

According to Goldstein (1996), borderline patients don't have a sense of consistency about things and people in their lives, have difficulty in experiencing an absent loved one as a loving presence in their minds and seeing the behaviours of others as part of the integrated whole. Moreover, the lack of self is a major

feature of BPD, which psychoanalysts have related to pathological splitting of the ego and the object (Goldstein, 1996). Splitting, usually accompanied by projection, is a primitive defence where an object is experienced as either all good or bad, leading to the split-off aspects of the self (Klein, 1952). Both splitting and projection are fundamental characteristics in borderline individuals, leading to black and white thinking about life events and significant others (Kernberg, 1967). Thus, one of the aims of psychodynamic psychotherapy is to promote psychic integration of the split-off elements of the client's psyche, so that their attitudes and behaviour towards other people will be improved in everyday life (Stone, 2006).

Recent research findings suggest the connection between splitting and sexual abuse, and proposes that splitting may be a sophisticated psychological mechanism for coping with traumatic experience (Calverley *et al*, 1994). According to Grohol (2007), splitting may also initiate strong and contradicting feelings in health professionals. Therefore, clinicians need to be especially aware of their own feelings toward the patient, especially counter-transference in dynamic therapy, as the client may behave in a way that is rather "inappropriate" (Grohol, 2007). It is important to understand that although they might need more care than many other patients their behaviour is caused by their disorder. Yet, mental health professionals often unfairly discriminated against individuals with borderline personality disorder for they are seen as "trouble-makers" and difficult to work with (Grohol, 2007).

### 1:2.3 The most significant findings of previous research studies on Borderline Personality Disorder

#### 1:2.3.i An overview of research findings on BPD<sup>5</sup>

There has been numerous research conducted within the interest of borderline personality disorder. The main focus of investigation has been on topics such as patients' drop-out rates from therapy (i.e.: Meares *et al.*, 1999; Gunderson, 2001); suicidal and self-harming behaviour (i.e.: Gunderson *et al.*, 2007); recovery following treatment (Leichsenring and Leibing, 2003); or the effectiveness of the different forms of psychotherapeutic interventions, particularly dialectical-behavioural therapy (i.e.: Linehan *et al.*, 1991), for both inpatient (i.e.: Desperles, 2010) and outpatient borderline individuals (i.e.: Giesen-Bloo *et al.*, 2006). While most studies seem to be quantitative in nature, using randomised controlled trials and self-reported measures, now there is an increasing number of qualitative research, using semi-structured interviews, on BPD and a few of those which combine both qualitative and quantitative methodologies (i.e.: Chiesa *et al.*, 2000). However, most qualitative studies have been interested in the borderline patient's experience of the disorder (i.e.: Holm, 2009), and of being in dialectical behavioural (i.e.: Hodgetts *et al.*, 2007; Hummelen *et al.*, 2007) and other types of psychotherapy. Thus, there seems to be very little research on mental health professionals' experience of working with BPD with only one qualitative study (Commons Treloar, 2009) found in the

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<sup>5</sup> Note that not all kind of research conducted on BPD are mentioned here. Nor all the studies referenced in this section are discussed in this research paper, due to the word limit and a focus on the significance of previous research for the current study.

literature. However, there were no studies found with a particular focus on therapists' lived experiences of working with BPD in any type of psychotherapeutic treatment.

There are, however, quantitative studies which have explored and compared therapists' counter-transference experiences with different patient populations, including borderline patients (e.g.: Salz, 1997), and examined the significance of the therapeutic relationship; mainly the working alliance in relation to working with BPD (i.e.: Bond *et al.*, 1998). Furthermore, an increasing number of quantitative (e.g.: Lewis and Appleby, 1988) and qualitative studies (e.g.: Nehls, 1998/1999) have explored mental health professionals' stigmatising attitudes towards patients diagnosed with BPD and its effects on the treatment outcome. Finally, there are a number of psychoanalytic authors who have published papers on the basis of their own experiences of working with BPD (i.e.: Goin, 1997/1998; Schwartz, 1999). In the following chapters, some of the most consistent and common findings reported in the research literature are discussed. However, due to word constraints in this paper, the focus is restricted to only those studies and findings, which may be the most relevant to the present research study.

### 1:2.3.ii *The significance of Counter-transference in working with Borderline Personality Disorder*

Research has found that many health professionals dislike working with people with borderline personality disorder, because of the negative counter-

transference feelings they experience (Binks *et al.*, 2009). For instance, Salz (1997) examined therapists' experience of counter-transference towards patients with a range of personality disorders. They found that practitioners felt more anger and resentment towards people with BPD than any other client type. Similarly, McIntyre and Schwartz (1998) investigated therapists' counter-transference feelings, using self-report questionnaires and audio-taped interviews of clients diagnosed with either BPD or severe depression. While therapists felt friendliness and submissiveness towards depressed patients, they experienced dominance, hostility and confusion toward borderline individuals. In contrast, Whitney (1995) reported no statistically significant differences in therapists' feelings towards their either depressed or borderline patients. However, it seems that there is evidence suggesting that there are some common negative counter-transference feelings experienced by therapists when working with borderline disordered patients.

According to Schwartz (1999), these feelings may include nervousness, fear, frustration, insecurity, anger or rage. Moreover, patients are likely to induce feelings of being tested, harassed, bullied or seduced out of role in the therapist (Schwartz, 1999). These occur because of the client's constant demands on the clinician, the constant suicidal gestures, thoughts, and behaviours, and the possibility of self-mutilating behaviour. In compensation, therapists may become either too sympathetic and submissive, or retaliating and punitive. When these feelings are not consistent with the therapist's personality or the expectation of their role, there is a better recognition of counter-transference



feelings (Hughes and Kerr, 2000). However, these are sometimes very difficult items for a therapist to understand and work with (Grohol, 2007).

There are two contrasting approaches defining counter-transference. According to the classical approach, counter-transference is the unconscious reaction of the therapist towards the patient's transference (Freud, 1957). On the other hand, the totalistic approach argues that counter-transference is the therapist's total emotional reaction to the patient in the therapeutic interaction. The latter view advocates that counter-transference may involve any conscious or unconscious attitudes or feelings towards the client, as well as the therapist's response to the patient's transference projections (Kernberg, 1975). While Freud believed that the therapist should not have any feelings towards the patient beyond a uniform and mild benevolence, other analysts not only acknowledged that the therapist has a wide range of feelings towards his patient, but also suggested that they should at times express them openly. Ferenczi (1926) was the first analyst to recognise the importance of counter-transference in the therapeutic relationship and the fact that healing comes from this relationship. According to Heimann (1950), what differentiates this relationship from others is not the presence of feelings in the patient and their absence in the analyst, but rather the degree of the feelings experienced and the use made of them by the therapist.

Gunderson (1996) maintains that due to a deep fear of aloneness borderline individuals idealise and cling to the therapist to reduce their fear of being alone. However, this might result in similar difficult and painful affects in

the therapist. When patients feel that the therapist fails, they attack the therapist in panic, anger and despair. Similarly, Hannig (1995) argues that because borderline individuals like to please others and tell them what they believe other people want to hear, they can become submissive to control a situation, but then they can suddenly change and attack, accuse, provoke, resent others or intensify a situation. Thus, the borderline individuals' psychological defence mechanism of splitting<sup>6</sup>, characterized by a polarization of good and bad feelings, can also induce counter-transference feelings within the therapist. In turn, it often results in destructive behaviour in patients' lives and confused reactions in health professionals (Goin, 1997). This may happen when a patient's idealization or devaluation of a therapist has a direct effect on the therapist's emotional response to the patient.

In the case of idealization, the therapist may unconsciously behave in such a way that they continue drawing attention from the patient. For instance, when the therapist sees the patient as vulnerable or in need of nurturance, they may treat that patient in a 'special' way (LaForge, 2007). On the other hand, devaluation may lead the clinician to develop a strong dislike for the patient. In this case, the practitioner may ignore or devalue the patient's complaints or may avoid interactions with the patient by referring them to another health professional (Schneidt, 2000). However, Goin (1997) argues that when the therapist ascribes borderline patients' behaviour to splitting, they may lose sight of the real meaning of the therapeutic transaction. This is because it can be too easy to blame borderline patients for therapists' distress and say 'they do this to

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<sup>6</sup> See the definition of 'splitting' in section 1:2.2.iii, on page 24.

us', but in fact it may be the therapists' empathy, compassion and desire to heal that 'does it to us' (Goin, 1997).

It seems that in psychodynamic psychotherapy, strong counter-transference feelings experienced by the therapist can become very important and useful material to reflect back to clients, in order to increase clients' unconscious awareness of their conflicts and attitudes. The recognition of countertransference also allows the therapist to remain calm and supportive and not to retaliate (Hughes and Kerr, 2000). This is important because borderline patients need someone who can provide them with the necessary experience of being understood and accepted, and who will not be overwhelmed by their needs, fears and anxieties (Goin, 1998). Hence, therapists need to monitor constantly their own strong emotional responses, which might also decrease over time (Schwartz, 1999).

*1:2.3.iii The significance of the therapeutic relationship and the working alliance for the treatment of Borderline Personality Disorder*

Some health professionals believe that a prolonged and trusting relationship with the therapist or therapeutic team can greatly help people with personality disorders in psychotherapy (i.e.: Hellerstein *et al.*, 1998). For the collaborative nature of a stable therapeutic relationship may provide the patient with the experience of a new and healthy way of relating, as well as it may help them psychologically develop in a more functional way. Therefore, the therapeutic relationship can contribute to the process of change (Winston, 2000).

Similarly, Paris (2005) proposed that through the therapeutic relationship the borderline client could effectively learn how to develop and maintain relationships. In turn, it may help them to break maladaptive patterns of behaviour and improve their extreme relationships with others. Although patients with BPD can be adept at eliciting a range of responses from therapists, via the mechanisms of transference and counter-transference, the in-depth nature of psychodynamic psychotherapy is believed to be very effective, in which the therapeutic relationship is seen as an important reflection of patients' past and present relationships (Goin, 1998).

Furthermore, Plakun (2001) contends that in dynamic psychotherapy it is vital for therapists to establish and maintain a good therapeutic alliance with self-destructive and suicidal patients, to be aware of therapists' contribution to clients' suicidal attempts and to pay careful attention to the transference and counter-transference processes. In clinical populations, the rate of suicide of patients with borderline personality disorder is estimated to be between 8% and 10% (Perry *et al.*, 1999). As it is difficult for these individuals to form a viable therapeutic alliance, it may be difficult to work collaboratively with the patient to protect them from serious self-harm or suicide (APA, 1994). Studies have shown that the quality of the working alliance is the most predictive factor of positive outcome for both short-term and long-term therapies for people with personality disorders (i.e.: Gabbard *et al.*, 1988/ 1994; Horvath and Symonds, 1991). This term has been used in the literature in several different ways, but it can be generally defined as the 'quality and strength of the mutual collaborative

relationship between the client and therapist within psychotherapy' (Hovarth and Bedi, 2002, p. 41).

Some research findings argue that only those patients with personality disorders, who have higher levels of ego strength and the ability to establish good working alliance benefit from interpretations, especially transference interpretations (Bond *et al.*, 1998). In many cases, transference interpretations may lead to deterioration in the already fragile working alliance and prevent good work (Gabbard *et al.*, 1994). For instance, Bond *et al.* (1998) examined the relationship between clearly defined therapist interventions and the therapeutic alliance with personality-disordered patients. They found that in psychodynamic therapy transference interpretations were followed by deterioration in the alliance when the working alliance was weak, but it was enhanced when the alliance was solid. On the other hand, there is evidence that when interpretations are well timed they may strengthen the working alliance in borderline patients. This is because the patient may have the perception that the therapist is trustworthy and understanding, who has something in common with the patient (Gabbard *et al.*, 1988). In another study on the therapeutic alliance, neither supportive nor exploratory psychodynamic therapies were correlated with positive outcome when the alliance was weak. However, when the alliance was strong, both types of therapies were more effective (Gabbard *et al.*, 1988).

According to Gunderson (2001), borderline people can work collaboratively, but they have great difficulty in establishing an alliance and maintaining it during periods of intense anxiety. For although they are able to

contract for therapy and sometimes experience their therapists as caring and likable, their internalized representations of others and of themselves are partial and polarized, typically leading to split-off, alternating idealized or persecutory perceptions of their therapists. As a result, they cannot establish a reliable working alliance until well into the treatment. Adler (1979) describes this as the “myth of the alliance” with borderline patients. He argues that not until patients internalize certain aspects of the therapeutic interaction, including the real qualities of their therapist that are lacking in themselves, are they able to work collaboratively with the therapist. When a good therapeutic alliance is established, borderline individuals have reached a neurotic level of functioning.

Gunderson (2001) believes that patients move through different phases in therapy: from engagement to a relational alliance, through acceptance of a positive dependency on their therapists to secure attachment and a true working alliance, and, finally, to consolidation and integration of their selves. Gunderson *et al.* (1997) reported that in a McLean prospective repeated-measures study, where thirty-five BPD patients started individual psychotherapy, a significant ‘relational’ alliance was found between patients and therapists. Moreover, most studies indicate that the severity of the client’s symptoms do not significantly affect the development of a positive alliance, as alliance development and severity seem rather independent. In fact, a strong alliance can compensate for the severity of the symptoms (Horvath, 1995). In an earlier mentioned outcome study, by Stevenson and Meares (1992), where a modified form of psychodynamic therapy was provided to borderline patients over twelve months, there was a focus on the therapeutic alliance. Not only a significant improvement

was found in many of the borderline patients' symptoms, but also 30% of the patients no longer met the criteria for the diagnosis of BPD. Thus, it seems that while the nature of the work with this patient population is very challenging, the establishment and maintenance of a safe and trusting relationship between therapist and the borderline individual is necessary (Goin, 1998).

*1:2.3.iv The significance and the impact of Empathy on the treatment of people with Borderline Personality Disorder*

Some psychodynamic writers argue that one of the most important elements of working with personality disorder in psychodynamic therapy is empathy. For example, Hannig (1995) suggests that a major factor in treating the borderline personality is compassionate concern, empathic understanding of early childhood trauma, and patience. Yet, there are also those who believe that therapists who are actively empathic, supportive, and involved are actually countereffective with those patients who react against authority, are poorly motivated, suspicious, highly emotionally sensitive and reinforcing their behaviour (Beutler *et al.*, 1986). Rogers (1957) defined empathy as the therapist's capacity to accurately understand, experience, and share the client's inner world and subjective experience. Psychodynamic therapists find empathy helpful in order to understand what the patient is trying to communicate, their general frame of reference, how they individually experience and interpret the world, and how that might be based in their experiential history (Bohart and Greenberg, 1997). When empathy is lacking in their interpersonal relationships, including the therapeutic relationship, the borderline individual often vacillates

between superficial relationships and intense, dependent relationships that are marred by primitive defences (Goldstein, 1996).

When borderline people are confronted on their choices, destructive behaviour, and defensive thinking, they may perceive the therapist as a disapproving, withdrawing parent. Consequently, they may resort to acting out and provocation, involving criticism, rejection and devaluation of the therapist, as well as other love objects (Hannig, 1995). If the borderline patient is not contained in the framework of a therapy, which allows for the release and integration of their deep pain, they could go through near-psychotic episodes (Gunderson, 2001). The therapist's deep empathic understanding of the borderline's pain, accurate interpretations and reflections can promote release of intense feelings, but at the same time provide support and reassurance to the patient (Hannig, 1995). Some argue that borderline patients can be very troubled with their maladaptive early relationships and thus unable to give a coherent account of them (Patrick *et al.*, 1994; Fonagy *et al.*, 1996). When therapists make erroneous interpretations in an attempt to understand the patient's experience, the borderline person may believe these are intentional and may abruptly withdraw from the interaction by feeling deeply hurt, angry, lonely and unfulfilled. Once again, only slow, careful and neutral empathy can help the patient relieve the pain and feel cared for (Hannig, 1995).

Both Barrett-Lennard (1993) and Jordan (1991) hold that the experience of empathy in psychotherapy facilitates the development of client relational skills, particularly the client's ability to empathize with others. According to Rothbart and his colleagues (1993), the borderline's ability to have empathy with



others is strongly associated with effortful control, with those high in effortful control showing greater empathy. It also seems that the individual with BPD is only able to express empathy towards others when the therapist interprets signs of the patient's distress or pleasure. On the other hand, a lack of empathy may contribute to difficulty with interpersonal relationships found in BPD (Posner *et al.*, 2002). In spite of these interpersonal difficulties, many clinicians have reported that borderline patients have an astute capacity to accurately read emotional expressions in others (i.e.: Krohn, 1974; Carter and Rinsley, 1977), which has also been supported by research evidence (Lynch *et al.*, 2006; Domes *et al.*, 2008).

Thus, it appears that BPD is characterized by both unstable interpersonal relationships and enhanced sensitivity to the mental states of others. Krohn (1974) labelled this contradiction a 'paradox', which is typical of borderline psychopathology. Yet, other BPD experts have labelled this acuity "borderline empathy" (Fertuck *et al.*, 2009). The most common assessment used to assess the accuracy of the perception of emotion expressed in human faces is facial emotion recognition (FER). In one study, Bland *et al.* (2004) reported that borderline patients were much less accurate than 'healthy controls' (HC; patients without a BPD diagnosis) in their capacity of identifying three negative facial emotions: anger, disgust, and sadness. However, there were no differences in FER of positive emotions.

In another study, Wagner and Linehan (1999) found that the BPD group was less accurate in identifying neutral faces than the HC group, but were more

accurate at reading fear facial expressions with an enhanced sensitivity in the FER. More recently, Fertuck *et al.* (2009) investigated enhanced mental state discrimination in BPD with a focus on the eye region. In line with previous research evidence (e.g. Lynch *et al.*, 2006), they found that BPD patients seem to be able to discriminate mental states for ‘neutral’ and ‘positive’ expressions more than ‘healthy controls’. In fact, they outperformed ‘healthy controls’ on ‘negative’ expressions at the trend level.

Furthermore, there is evidence that empathy may help therapists overcome their anxiety leading to appropriate therapeutic responses. In a study, by Peabody and Gelso (1982), high empathy was associated with decreased countertransference with borderline patients. However, when very early conflicting object relationships manifest in the transference, the therapist may experience the process of empathic regression in order to maintain therapeutic contact with the patient (Kernberg, 1975). In this process, the clinician’s own early experiences may be reactivated, alongside the mechanism of projective identification, which can lead to a number of dangers. For instance, the reappearance of anxiety might be directed towards the patient, there might be a certain loss of ego boundaries in the interaction with a certain patient and there might be a tendency to control the patient, which the therapist identifies with an object of the therapist’s past. This may then lead to a parallel process between the therapist and patient (Kernberg, 1975).

*1:2.3.v A qualitative study of clinicians' experience of working with borderline personality disorder*

Recently there has been a growing body of research exploring the attitudes of mental health professionals towards individuals with borderline personality disorder. Most studies found that the attitudes amongst health professionals are likely to be negative and derogatory (e.g. Commons Treloar and Lewis, 2008; Bowers and Allan, 2006; Deans and Meocevic, 2006; Potter 2006). However, a recent quantitative study (Commons Treloar and Lewis, 2008) reported that attitudes were different between clinicians in emergency medicine and those in mental health service settings. Firstly, it was reported that clinicians in the medicine emergency field had more negative attitudes towards patients with BPD than did the clinicians in the mental health field. Secondly, the findings showed that female practitioners displayed more positive attitudes towards borderline patients than male practitioners. Furthermore, allied health professionals, such as psychologists and social workers, seemed to express more positive attitude ratings than health professionals within occupational areas of nursing and medical fields.

To follow up these results, and to explore them in more depth, Commons Treloar (2009) used a qualitative methodology in which 140 clinicians (48 males and 92 females) were interviewed about their experience of working with BPD across emergency medicine (medical or psychiatric registrars and officers, or psychiatrists) and mental health service settings (nurses, including both general and mental health registration, and allied health clinicians, including

psychologists, social workers, and occupational therapists) in Australia and New Zealand. The main focus of investigation in their thematic analysis study was clinicians' negative attitudes towards borderline patients and the main challenges they faced in their work with this population. The study found that clinicians had difficulties in understanding and responding to borderline patients in their clinical work, due to their uncertainty and their lack of training of knowing how to respond to this distressed patient group. In addition, it was also found that they felt frustrated and inadequate to handle the challenges of working with this clinical population. The feelings of frustration were also partly directed towards their current health system, which, according to clinicians, failed to address the needs of these patients. In addition, it was also felt that techniques and strategies were needed to improve service provision with BPD, as there was limited access to resources such as training, education and supervision.

Therefore, it was suggested that the lack of these resources might have contributed to clinicians' negative attitudes towards BPD, which had been so repeatedly reported in the research literature. Furthermore, Commons Treloar (2009) found that, on the basis of the presence of BPD as a diagnosis, clinicians had biased and prejudiced views of borderline patients. Thus, this led to their tendency to refuse help to them and to their inability to have objective assessments of borderline patients' needs. This finding is consistent with the findings of Lewis and Appleby (1988).<sup>7</sup> Moreover, some clinicians felt that these patients were manipulative and that they used their diagnosis as an excuse for their difficult behaviours. As a result, these difficulties and negative feelings had

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<sup>7</sup> See this study described in section 1:2.3.vi, page 37.

a negative impact on the therapeutic relationship between clinicians and patients, which most clinicians found very challenging to work with.

*1:2.3.vi Stigma of borderline personality disorder & its implications in clinical work*

Aviram *et al.* (2006) argues that due to challenging and unpredictable behaviours and intense emotions related to BPD, therapists may find it difficult to view patient's problems as the 'nature of the pathology' instead of the 'nature of the individual'. This is because when the individual patient is perceived to be a problem, the therapist is more likely to have a biased rather than a neutral approach towards them. Stigma is a negative attitude that causes an individual to devalue and to think less of another person (Katz, 1981). Many patients with mental health illnesses are perceived weak, inhuman, or 'less than' and become isolated, due to the label of their diagnosis (Westbrook *et al.*, 1993). People in stigmatised groups are often seen to have a blemish of individual character, which directs the focus from attribute, the mental illness, to the person (Goffman, 1963). According to Hinshelwood (1999), mental health professionals are likely to 'emotionally retreat' from people with personality disorders, because patients bring up difficult feelings in them, which challenge their assumptions about their professional identity. Goffman (1963) writes that this 'voluntary distance' may lead clinicians to miss significant information about the subjective experience of the individual with the diagnosis.

A study by Lewis and Appleby (1988) reported that the presence of a personality disorder diagnosis evokes pejorative, judgmental and rejecting

attitudes in clinicians. As borderline patients are sensitive to rejection and abandonment, they might respond negatively to such therapist behaviour. Furthermore, they found that patients with a diagnosis of BPD might be rejected to be seen as ill, as opposed to patients with any other bio-chemically determined diagnosis. Consequently, clinicians may feel that these patients do not deserve treatment, even when there are symptoms, and turn them away. Lewis and Appleby (1988) argue that this prejudice may be based on clinicians' belief that people with personality disorders are not mentally ill because they are able to control their symptoms and behaviours.

A number of authors believe that mental health professionals are just as susceptible to stigmatizing behaviour as the general population are (e.g. Farrell and Lewis, 1990; Lauber *et al.*, 2006). According to Ay *et al.* (2006), these behaviours are only slightly if at all reduced by medical education. In a study by Chin and Balon (2006), it was found that greater education, further experience or choice of specialty did not have a positive influence on resident physicians' attitudes towards mental illness. In fact, the researchers reported that stigmatizing attitudes tended to be only lower when the clinicians had family members with a psychiatric illness (Chin and Balon, 2006). Sartorius (2002) suggests that iatrogenic stigma is caused or perpetuated by mental health professionals. For instance, psychiatrists may contribute to it by their own behaviours and attitudes. Therefore, they should be aware that diagnosing a person with mental illness leads to issues such as labelling (Sartorius, 2002).

Shedler and Westen (2004) describe how the challenge in treating BPD has resulted in having a prototype against borderline patients, who are seen as ‘manipulative’, ‘difficult’, ‘treatment resistant’, ‘attention seeking’ and ‘demanding’ (e.g. Nehls, 1998; Stone *et al.*, 1987). While these descriptors may reflect aspects of patients’ behaviour, they result in discrimination, early treatment termination and negative therapeutic outcomes. In a pilot study, by Gallop and Wynn (1987), psychiatric nurses and residents identified typical behaviours and characteristics of ‘difficult patients’, including borderline people. Content analysis revealed that feelings of ‘lack of control’ and ‘incompetence’ were the main themes these mental health professionals had in response to borderline patients. In order to defend against these feelings, the nurses wanted actions from the patients, whereas the resident clinicians distanced themselves. Both of these responses contributed to patients’ negative experiences and negatively influenced the treatment.

According to Heller (2002), the BPD term and the label are inaccurate, as the cause is a biologically based brain disorder rather than a ‘flawed personality’. Evidence comes from recent research that connects BPD to a limbic system dysfunction, which is the emotional center of the brain. The amygdala and hippocampus are vital parts of the limbic system, which regulate emotional expression, such as fear, rage and automatic reactions (such as impulsive behaviours) and emotional memory. The pre-frontal cortex is another important structure that might play an essential role in emotional regulation. Research found that volume of the hippocampus (16%) and amygdala (7.5%) was smaller in the BPD group than in the control group. In another study, a link between

BPD and low-level brain activity was found in the pre-frontal cortex (Soloff, 2000).

Linehan (1993) argues that borderline personality disorder is linked with patients' difficulty in emotional dysregulation and it is thus caused by increased emotional sensitivity and heightened emotional intensity. Thus, Heller believes that the disorder should be given a name that reflects a biological disorder of the brain's limbic system and he proposed the term 'dyslimbia'. "Dys" means malfunction, and "limbia" meaning from the limbic system. "Dyslimbia," then, is a "malfunction of the limbic system". Then, he believes, there would be much less stigma attached to it. Porr (2002) believes that "Emotional Regulation Disorder" or "Emotional Dysregulation Disorder" are the most likely to be adopted by the American Psychiatric Association (APA). Thus, these writers argue that considering the negative effect of BPD, mental health professionals should indeed question the accuracy of the "BPD" as a diagnosis and its stigmatizing effect on people diagnosed with it.

### *1:2.3.vii The relevance of this study to the field of Counselling Psychology*

Although this study focuses on exploring psychodynamic psychotherapists' lived experiences of working with BPD clients, rather than the experiences of counselling psychologists, this study may also be relevant to the field of counselling psychology for several reasons. First, counselling psychologists are trained to practice within a range of modalities, including the psychodynamic modality, with clients who might present with a range of different mental health difficulties. In this study psychotherapists practice within a contemporary psychodynamic modality, which is understood as a 'two-person'



psychology, with a focus on the collaborative and shared understanding of the client's distress and an exploration of both the patient's and the therapist's contribution to the therapeutic relationship, rather than in the 'one-person' traditional psychoanalytic model (Shedler, 2010). Since counselling psychologists value the therapeutic relationship, as well as the relational elements, the therapist's role and intersubjectivity in their practice (Corrie and Lane, 2006), the therapists' way of working in this study seems similar to the way in which psychodynamic counselling psychologists work in their practice.

Second, while counselling psychologists do not diagnose individuals in their practice, due to the pluralistic nature of their profession, they tend to engage in a dialogue with other mental health and psychotherapy fields and professionals (Milton, 2010). As a result, not only are they aware of the existence of the psychiatric diagnosis called BPD, but they might also work in certain settings where clients do come with this specific diagnosis.

Third, due to the phenomenological nature of this study, which provides an in-depth and idiographic exploration of psychodynamic psychotherapists' lived experience in its own terms, this research study can provide the type of data and knowledge<sup>8</sup> which resonate for psychodynamic counselling psychologists who work with individuals diagnosed with BPD and which they might find useful in their practice. Thus, the findings of this study might have implications for the practice of counselling psychologists.

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<sup>8</sup> See a discussion of this in section 2.2.1 '*Epistemology*' on page 54.

#### 1.2.4 Conclusion and the aims of the current research study

This research study aims to contribute knowledge to the field of psychodynamic psychotherapy and counselling psychology for both theoretical and practical reasons. The main purpose of this study is to provide the type of data which both counselling psychologists and psychodynamic psychotherapists can find useful, in order to enhance their existing knowledge about working with people with a BPD diagnosis, and which can also inform their practice when working with this patient population, as no significant research has of yet specifically focused on this. The research literature indicates that mental health professionals can find treating people with BPD very difficult. Thus, many therapists tend to avoid working with this patient population, leaving many patients without the necessary help for treatment. Previous studies, mainly quantitative studies, have found evidence that patients with BPD can evoke certain counter-transference feelings in clinicians, which may make the therapeutic relationship and the working alliance difficult to maintain. While empathy has been reported to be imperative during the work with these patients, therapists' attitudes and the pre-existing assumptions about this group promotes stigma within the mental health profession, which may involuntary reinforce patients' difficult behaviour in therapy and thus affect treatment.

The literature also suggests that the traditional psychodynamic model may not be effective for borderline clients, whilst found DBT as the most prolific and the most sought after therapy to treat these individuals. Therefore, findings in this study may have implications for the approach that psychotherapists and counselling psychologists take towards working with borderline clients within

the psychodynamic modality. The main aim of conducting the study was to investigate what lived experiences psychodynamic psychotherapists might have of working with borderline personality disorder within psychodynamic psychotherapy. The nature of the research is phenomenological, without any hypotheses to test out. The main research question, which was addressed, is *“What lived experiences do therapists have of working with borderline personality disorder in psychodynamic psychotherapy?”*

## Chapter Two: Method, Epistemology and Methodology

### 2:1 Method

#### 2:1.1 Design

This study employs a qualitative methodology for a number of reasons. Firstly, a qualitative design seems more appropriate than quantitative measures for exploring the meaning of participants' experiences. This is because it allows phenomenological understanding, in depth exploration, and analysis of how therapists' experience takes place. Secondly, qualitative research tends to be holistic and explanatory rather than reductionist and predictive; and it allows the researcher to tap into the personal world and perspectives of the participants (Willig, 2001) and provide the type of data and knowledge which would be more useful for the practice of psychodynamic psychotherapists and counselling psychologists and which would better resonate with their own professional identity.

#### 2:1.2 Participants

The recruitment of participants involved contacting a random sample of 250 Chartered Counselling Psychologists through the register of counselling psychologists on the BPS website. Later, a further 300 emails were sent to accredited psychotherapists through the register on the BACP, UKCP and BPC websites. An email was sent to all counselling psychologists and psychotherapists to invite them to participate in the study, including an *Information sheet* about the research (Appendix 1), with the *Inclusion criteria*

(Screening questionnaire; Appendix 2) attached. Participants who responded were selected through an initial telephone call to ensure that they met the criteria for the study. An *Advertisement letter* (Appendix 3) requesting participants was also placed on the DoCP professional website.

The *Screening questionnaire* (Appendix 2) with the inclusion and exclusion criteria ensured that all participants should be either BPS chartered counselling psychologists, or BACP, UKCP and BPC chartered psychodynamic psychotherapists. They also all needed to have at least 3 years post-qualification experience of working with clients with borderline personality disorder (BPD). They all had to be currently practising in the psychodynamic model, and had to be working in a voluntary setting, private practice or in the National Health Service (NHS). Permission and ethical approval from the NHS was not needed, as recruitment did not take place through the NHS. Finally, all therapists needed either to have seen borderline clients for at least 20 sessions or to have recently finished therapy with their clients. Those participants who did not meet one of these criteria were excluded from the study.

This study involved interviewing a sample of five participants twice about their experience of working with BPD in contemporary psychodynamic psychotherapy<sup>9</sup>. All participants were psychodynamic psychotherapists. Four of the participants were in private practice and one of them was working as a doctor

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<sup>9</sup> For a description of what this study understands by ‘contemporary’ psychodynamic psychotherapy, see section 1:2.3.vii, on page 40.

in the NHS in London. This study initially aimed to include counselling psychologists because the researcher is a trainee counselling psychologist. However, since it proved difficult to find counselling psychologists who worked with borderline clients within a psychodynamic model, further ethical approval was sought in order to recruit psychodynamic psychotherapists. A sum of £20 was offered to them for each interview.

Interpretative phenomenological analysis (IPA) attempts to recruit a fairly homogeneous sample for whom the research question is significant, thus, inclusion criteria were used, in order to screen the sample and to avoid upsetting the data. Homogeneity, however, implies a partially practical and a partially interpretative problem (Smith *et al.*, 2009). Practical problems include finding out which people are suitable candidates and how easily they can be connected. Interpretative problems include thinking about the ways in which participants vary from one another and how this variation can be contained within an analysis of this phenomenon. As counselling psychologists tend to work differently from psychodynamically and psychoanalytically trained therapists, due to their non-pathological view of psychological distress, this study defined the boundaries of its relevant sample. For this reason, it was intended in this study to interview one type of therapy group- either counselling psychologists or psychodynamic psychotherapists. Since psychodynamic therapists were more willing to take part in this research, the sample was restricted to this group only, and no counselling psychologists were included.

It could be thought that a group of five participants would not provide a fair representation of the population. However, because the main concern of IPA

is to gather a detailed account of individual experience and to focus on quality rather than quantity, IPA studies benefit from a solid focus on a small number of cases (Smith *et al.*, 2009). All participants were females and trained as psychoanalytic psychotherapists. A brief summary of the participants' background is presented in Table 1; personal details (age and name) are protected due to confidentiality. The aim of this study, therefore, was to explore and understand the lived experience of a small number of participants in detail, rather than testing a hypothesis on a large sample (Smith, 1996). Smith *et al.* (2009) also argue that IPA studies benefit from a focus on a small number of cases and it could be more problematic to have a 'too large' rather than a 'too small' sample. Furthermore, Smith and his colleagues (2009) propose that for professional doctorates it is the number of interviews, rather than the participants, that contribute to successful analysis in IPA, requiring time, reflection and dialogue, which bigger datasets are likely to inhibit.

**Table 1: Table summarising participants, who were interviewed in the order set out in the table.**

	Agnes	Melanie	Leah	Maria	Helen
Date of Interview 1	October 2010	October 2010	October 2010	October 2010	November 2010
Date of Interview 2	October 2010	October 2010	October 2010	October 2010	November 2010
Gender	Female	Female	Female	Female	Female
Number of years of experience	3	6	10	15	16
Psychotherapeutic Orientation	Psycho-dynamic	Psycho-dynamic	Psycho-Dynamic	Psycho-Dynamic	Psycho-Dynamic
Number of session with client	81	Over 20	Over 20	Over 20	40
Number of current borderline patients	One	Several	Several	Several	One

### *2:1.3 Data Collection*

There were two interviews, each lasting one hour, which facilitated the collection of the qualitative data (there was also some time provided for an introduction and debriefing). The first interview was unstructured, while the second interview was a semi-structured interview. The duration of the interview was subject to change, due to the flexible nature of unstructured and semi-structured interviews. An unstructured interview usually has a single main question, which is asked at the beginning of the interview. The interview depends on how the participant answers this question. Using this approach allows the researcher to make use of IPA's epistemology to the greatest extent and to investigate unexpected findings. A semi-structured interview, on the other hand, is a flexible, non-formalised process. It allows the researcher to explore certain themes and ask new questions during the interview, based on the responses of the interviewee, while respondents can also ask questions of the interviewer (Lindlof and Taylor, 2002). Here, the main focus of the unstructured interview was on the therapist's experience of working with BPD in a psychodynamic or psychoanalytic setting.

The questions in the semi-structured interview were informed by quotes and metaphors, selected through studying the transcript of the first interview (Flowers, 2008)<sup>10</sup>, and explored in more detail, alongside any other new information emerging in the second interview. There was a week between the first and the second interview, which seemed appropriate in terms of not

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<sup>10</sup> See the advantages and disadvantages of multiple interviews in section 2:1.6 on page 52.



overburdening the participants and yet ensuring that their memory was still fresh to avoid repetition and a parallel process (Flowers, 2008). The interviews took place at the participants' house or place of private practice. Participants undertook the study individually, and they were introduced to the study with a brief description of the research questions and tasks. They were given a pack including an *Informed consent form* (Appendix 4) and an Information sheet about the study. Informed consent covered the confidentiality of the interviews (which could be breached for three reasons: should a participant be harmful to oneself or others; unethical issues; and for legal reasons) and an agreement to allow audio-recording of the interviews. Certain personal details were asked of the participants (age group, gender, their therapeutic orientation, the length they had been working with BPD; see Appendix 5) some of which were made anonymous at the point of transcription. Participants were also given a screening questionnaire to ensure they met the inclusion criteria. They were informed that they had the right to withdraw from the study at any time.

In the *Interview schedule* (Appendix 6) participants were asked one question in the beginning of the interview as well as further questions, which emerged from the conversation, in order to allow them to elaborate on their answers. The main idea of the phenomenological perspective in this research was to explore the question without any assumptions and ideas, and to focus on what emerged during the research process. The aim was to explore the depth and complexity of the participants' meaning making by being an active listener and by allowing the participants to lead the interview, rather than directing it, rigidly based on the interview schedule. It is recognised that each individual tells their

story with varying degrees of ease, since they might view them as being not very interesting to the listener (Eatough and Smith, 2006). Therefore, it is usually better to ask open, indirect, and not too many questions in the interview, which do not lead towards a particular answer, with minimal verbal input from the researcher (Smith *et al.*, 2009). It is also vital not to make too many assumptions and preconceptions about therapists' experiences and views of their personal world, due to the phenomenological nature of the research.

Thus, the starting question for the first unstructured in-depth interview was: "Could you please tell me about your experience of what it is like for you, as a psychodynamic psychotherapist, to work with a client who you believe has a condition called borderline personality disorder?" Questions for the second semi-structured interview included something like, "Can you tell me more about your experience of how your difficulty in containing the client affects you as a therapist?" "In the first interview you talked about the importance of the relationship and I wonder if you could tell me what it means for you when working with this borderline client?" "How do you feel your client experiences you when you have those negative feelings you described last week?"

A few questions in response to something that participants can talk about at some length, or to facilitate their elaboration on their answers, also emerged in the interview. These questions were, "Can you tell me a bit more about that?"; "How do you feel when that happens with your client?"; "How did you deal with the situation?" At the end of the interviews, participants were asked if they had any concerns or questions and were handed a *Debriefing information* sheet

(Appendix 7), which included details of withdrawal and follow up support in case they required it. Finally, there were two pilot interviews carried out before the actual research interviews took place, in order to check the feasibility and to refine the interview schedule (Sampson, 2004).

The participants were two qualified female contemporary psychodynamic psychotherapists, who worked at the agency where the researcher practiced as a trainee counselling psychologist at the time. Both therapists took part in an unstructured and a semi-structured interview in which the above described procedures were followed. The second interview took place three days after the first interview for the first therapist and ten days later for the second therapist. The aim was to explore how a shorter and a longer break between the two interviews would be experienced by the participants. Both participants gave the researcher valuable feedback at the end of the interviews, which informed the design of the current study. The main implications were that both therapists found that the researcher had a tendency to be a bit directive in the beginning of the unstructured interview, which needed to be monitored in the current study. Furthermore, the first participant found that three days between the two interviews were somewhat short, as it was overwhelming to talk about her experiences. On the other hand, the second participant found that a ten-day break was too long, as there was a likelihood of things being repeated, due to her inability to remember what she had said before. Thus, there was a consensus that a one-week break between the two interviews might be more appropriate for the participants.

#### *2:1.4 Ethics*

Brinkmann and Kvale (2008) argue that qualitative research is concerned with ethical issues because ‘The human interaction in qualitative inquiries affects researchers and participants, and the knowledge produced through qualitative research affects our understanding of the human condition’ (p. 263). Thus, ethical issues arise from the beginning of the research when a research question is formulated, and they are present throughout the interactions with the research participants and the process of publishing the research findings. Furthermore, Brinkmann and Kvale (2008) argue against following ethics as a rule. They believe that ethical issues cannot be addressed and solved during the planning stages of the research, since these concerns will appear throughout the research process. Instead of trying to learn the ethical rules for the treatment of participants, researchers should develop adequate ‘ethical research behaviour’ (Brinkmann and Kvale, 2008, p. 276) and ‘the ability to sense, judge and act in an ethically committed fashion’ (p. 278). This may be more useful in qualitative research, in which requirements such as informed consent and confidentiality could become an ethical challenge. Moreover, there might be a risk of quasi-therapeutic relationships developing between the researcher and the participant in in-depth interviews, which could lead to certain feelings and expectations on the part of the participant that the researcher may not be able to deal with. Thus, as much as it was possible, the connection between certain participants and their data were left in the interview room. It is the data on which the researcher was concentrating.

The basic ethical considerations, which applied to the treatment of participants in this research, are consistent with Elmes and his co-workers' (1995) proposal of ethics: *Informed consent*. The participants were informed about the research procedure and were asked to give their consent to participate in the research before data collection took place. *Debriefing*. The researcher ensured that, after the interviews, participants were informed about the aims of the research. They were also informed that they could also have access to any publications arising from the study, in which they participated. *Right to withdraw*. All participants were given the option to withdraw at any time without giving a reason, by quoting an 8-digit ID number (i.e.ABCD1234), which was cited on the debriefing form. *Confidentiality*. Participants were also told that no personal information or any specific information with regard to session content and interventions provided to the researcher with would be made available to anyone else, in order to ensure anonymity. Each participant was given the right to have access to the completed transcripts in order to provide them with the opportunity of adding comments and to ensure that the experiences described were accurate. All interview recordings and transcripts were confidential. All references to personal details (i.e.: age, gender) were removed at the point of transcription. Those, which could not be removed, were treated as confidential and anonymous. They were kept in a secure place at the house of the researcher until the examination period is over and for the following 10 years afterwards. This will be in accordance with University policy. *No deception*. There was no deception of participants or any risk to the participants.

*The British Psychological Society Code of Ethics and Conduct* (BPS; 2009) and *The Division of Counselling Psychology Professional Practice*

*Guidelines* (BPS, 2005) were consulted and followed to ensure that ethical procedures were followed by the researcher. The following ethical guidelines were applied: informed consent, risk assessment, right to privacy and anonymity, protection from harm, sensitivity and duty of care and the right to withdraw. The ethical principle of beneficence, non-maleficence, autonomy and fidelity were also utilised (McLeod, 2003). It was crucial to ensure that the participants were treated as collaborators, as opposed to objects (Arskey & Knight, 1999). Furthermore, the ethical code followed by the institution under which the therapist worked was diligently consulted. The participants were protected from any harm or loss, and their psychological well-being and dignity were preserved at all times. The researcher endeavoured to make sure that the participants fully understood the nature of the research and told them that, if at any time during the interview they felt uncomfortable, they were free to say so with no detrimental consequence to themselves. A list of sources of psychological therapies and support groups available to all participants were provided to each participant.

### *2:1.5 Payment*

Since it was very difficult to find participants, who met the inclusion criteria, a payment of £20 was offered to each participant for each interview, for which ethical approval was granted by the ethical board of Roehampton University. Head (2009) argues that paying participants may have implications in terms of practical, methodological and ethical issues, which should be considered by qualitative researchers. There is also evidence that monetary incentive can increase response rates when compared to the situation where there

has been no payment (i.e.: Singer and Kulka, 2002; Edwards et al., 2002, p. 1183). Thompson (1996) found that payment in his study ‘helped avoid the bias which might have resulted from the omission of those who declined to participate because they put a greater value on their time, energy and views’ (p.5) and that it helped to ‘equalise’ the uneven power relationships between interviewer and participant. Similarly, other researchers have emphasised the importance of payment in order to express appreciation for the time given by the participant to a study (Rowlingson and McKay, 1998). On the other hand, Head (2009) argues that payment might make participants feel that they have nothing ‘useful’ to say.

Participants in this study were informed that they were being rewarded for their time and not for what they said, and therefore the payment was made to them at the end of the second interview. According to Sullivan and Cain (2004), payments should not be so high that this encourages participants to participate when they would rather not. For this reason payment of £20 per interview was offered to each participant, which was also the amount recommended by the university as a maximum limit. According to *The BPS Ethical Principles* (2009) for Conducting Research with Human Participants, ‘The payment of participants must not be used to induce them to risk harm beyond that which they risk without payment in their normal life style’. There is also a concern that payment could encourage participants to give false information to be eligible for a study (Russell *et al.*, 2000) or say what they feel the researcher wants to hear (McKeganey, 2001). The researcher was aware of these issues at the time of data

collection, and of how they might influence the interpretation of the interviews and analysis of the qualitative data (Head, 2009).

#### *2:1.6 Advantages and disadvantages of multiple interviewing*

Recently, Flowers (2008) highlighted time-related issues within qualitative research and argued that these can help maximise our research skills regardless of the epistemological or ontological framework underpinning the research. While one-off interviewing can cause the researcher anxiety, because of the pressure to build a quick relationship with the participant and the difficulty in remembering what the participant said, multiple interviews may lead to pragmatic issues. For instance, the characteristics of the researcher, such as poor techniques, may influence decisions to use repeat interviews. However, the analysis of multiple interviews involves putting the interviews together and treating them as if they were a single mega interview, which has the advantage of keeping the analytic process simple and clean. One of the reasons it was decided to interview the same participant twice in this study was related to setting an agenda for the second interview, on the basis of the researcher's recollections, and the selection of quotes and metaphors located through studying the transcript of the first interview (Flowers, 2008).

According to Flowers (2008), the disadvantage of this 'soft' approach is that the social context of the multiple interviewing and the rapport between the interviewer and the participant can be minimised. Furthermore, although the interview is participant-led, there is always a danger that the content of the



second interview may become researcher-led. However, the greatest advantage of adopting multiple interviewing is the opportunity for richness and depth in investigating the research topic within each interview. Moreover, the trust and relationship developed between the two parties can facilitate greater disclosure by the participant. There is also an awareness of possible epistemological issues arising, because the interviews may have become gradually more analyst-focused. On the other hand, during the process of interviewing the same participant twice, the interaction may become more interpretative, because social dynamics can maximise the researcher's interpretations (Flowers, 2008).

## 2:2 Epistemology

### 2:2.1 The significance of epistemology in qualitative research

The majority of borderline research has been conducted within the medical model, from a positivist perspective, relying on hypothetico-deductive methods and statistical analysis in order to test a priori hypothesis and to make generalizations from the findings (e.g.: Meares *et al*, 1999; Clarkin *et al.*, 2007). Qualitative research, on the other hand, can be conducted from within different epistemological and ontological frameworks, because various methodological approaches are based upon different preconceptions about the nature of the world, the meaning of knowledge and the role of the researcher in the research process. IPA has been selected as the methodology to conduct research interviews (methods) and analyse the data. Phenomenology is the theoretical perspective that lies behind the chosen methodology, bringing a set of assumptions to the research study. Phenomenology is informed by both ontology, to understand what is, and epistemology, to understand what it means to know and how we know what we know (Crotty, 1998). Thus, ontological issues emerge alongside epistemological issues.

Madill *et al.* (2000) argue that it is important that qualitative researchers should hold a comprehensive epistemological position, so that their research can be consistent, and that their findings can be evaluated appropriately. In order to evaluate a qualitative study, researchers need to know what it was they wanted to find out (i.e. the research question) and what kind of knowledge they were trying

to provide (i.e. their epistemological position). Thus, the chosen research methods must be relevant to the research question and consistent with their epistemological position (Willig, 2001). An important area of epistemological debate in qualitative research is the extent to which any method can provide access to the experience of the personal world of the research participant. That is, the assumptions we make about what it is possible for us to know and how we can obtain that knowledge. Whereas there is general agreement about the two main ontological positions, with *realism* being on the one end of the continuum and *relativism* on the other, there is a range of epistemological positions, which different authors may apply differently for the same research methodology. For instance, Crotty (1998) identified three epistemologies as *objectivism*, *constructionism* and *subjectivism*.

Both the research question and the title pose an ontological and epistemological tension in the present study. That is, the definition of BPD and the set of DSM-IV criteria for diagnosis of BPD are posited in *realism*, in ontology, describing what and how borderline behaviours are and asserting that these criteria exist outside the mind. Similarly, these criteria are located in *objectivism*, in epistemology, as they represent a positivist stance of an objective and absolute existence of people's meaningful reality, implying that meaning exists in the set of criteria independently of any consciousness (Crotty, 1998). However, from an ontological perspective, therapist experience can be based in *relativism*, as their experience is relative depending on their own perception and interpretation of that experience. Similarly, from an epistemological perspective,

therapist experience is *subjective* rather than objective, due to both therapists' and patients' individual differences and perceptions of the world.

Subjectivism is an epistemological underpinning, which argues that meaning is not a result of an engagement between object and subject, but rather it is created out of nothing (Crotty, 1998). However, therapists' experiences cannot be created or given meaning without an engagement with their patients, who they believe have BPD, because their experience is constructed out of working with borderline patients. Without the patients, the therapist would not have an account of what it is like working with this patient population and therefore, would not be able to share their lived experiences with the researcher. Thus, *constructionism* rejects both the objectivist view, that there is an objective truth to be discovered without the operation of any consciousness, and the subjectivist view, that meaning is constructed without the existence of an object. According to constructionism, there is no meaning without a mind, since truth or meaning comes into existence in, and out of, our interaction with the realities in the world. Thus, meaning is constructed, rather than discovered, in which object and subject have complimentary roles (Crotty, 1998).

### 2:2.2 Contextual constructionism

In this study, participants' accounts are grounded in a particular context, within which they were produced. Thus, this study positions itself in a *contextual constructionist* epistemology. IPA attempts to understand how a particular phenomenon is experienced by certain people in a certain context. Experience, in

a phenomenological sense, is very complex, as it is uniquely embodied, perspectival and situated, and thus, it is similar to an idiographic approach. Hence, this study recognises that therapists' accounts of reality are subjective and influenced by the context of the phenomenon, particularly by therapists' experience and perceptions, the social environment, and the interaction between the participant and researcher (Ponterotto, 2005). Furthermore, as the researcher is interested in therapist experience of working with BPD within a specific context, namely the psychodynamic approach, therapist experience becomes contextual and standpoint-dependent. That is, psychodynamic or psychoanalytic therapists are likely to give different accounts of their experiences of working with BPD patients from those therapists who work within different psychotherapeutic modalities, such as existentialist or cognitive-behavioural therapy.

There is a body of research evidence, based on quantitative studies, claiming that working with borderline patients, especially within psychodynamic psychotherapy, is very difficult and demanding, due to the negative feelings induced in therapists (e.g.: Winston, 2000; Grohol, 2007). While objectivism views working with individuals with BPD in terms of the measurable negative impact of the condition, constructionism holds the view that working with borderline patients becomes difficult only when they are defined or felt problematic and they are in need of a solution (Spector and Kitsuse, 1977). It is the social construction or subjective interpretation, which defines a problem in constructionism rather than the nature of the condition itself. Thus, working with borderline patients is not different from working with any other patient

population. It might only become a different experience when patient's behaviour with a condition called BPD is experienced differently, either in a positive or negative way, by therapists.

According to Best (1995), contextual constructionism “falls somewhere between the two extremes of objectivism and strict constructionism” (p. 345). From a contextual constructionist perspective, claim making about a certain phenomenon is important, which can either be validated or refuted with the available evidence and, which is grounded in different social, historical, economical and political contexts. It is the claim and the social construction of the claim made by the individual that is the focus, not the truth value of the claim (Goode and Ben-Yehuda, 2009). While the contextual constructionist is able to draw discrepancies between objective and subjective accounts of what a phenomenon is, the strict constructionist is not, as he does not recognise the existence of objective views (Goode and Ben-Yehuda, 2009). For objectivism neither defines what working with people with BPD is, nor does it determine what subjective experiences therapists may have. Contextual constructionism views the objective and subjective dimensions as independent of one another, rather than contradictory. On the other hand, the DSM-IV criteria for BPD have a positivist stance with an absolute and objective view, and the purpose of informing therapists of what behaviours and characteristics people with BPD might have.

The contextual constructionist epistemological position which this IPA study has adopted is in line with the philosophies and ethos of counselling

psychology, which recognises that while classification of ‘disorders’ might make sense when viewed from within the medical model, this view is not without problems. For this view assumes that ‘truth’ can be discovered in a ‘knowable’ world, where that individual’s distress can be classified as a distinct entity, and that ‘psychopathology’ is a ‘thing in itself’. These realist and objectivist views are challenged by the postmodern position of counselling psychology proposing that ‘universal truth’ claims are not possible, as human beings have diverse and unique experiences and that mental health difficulties are constructed within different socio-cultural and historical contexts (Milton, 2010).

According to Guba and Lincoln (1994), the world or a certain phenomenon can exist without a mind, whereas meaning of that world cannot. Thus, the DSM-IV criteria can exist without therapist experience or any consciousness, whereas therapist experience cannot exist without consciousness, which is necessary to make sense of their experience, and to create an account of it. Here IPA allows the researcher to explore therapists’ meaning making of working with BPD in psychodynamic settings in its own terms; and to provide a rich and a comprehensive description of that experience (Smith *et al.*, 2009). Thus, the epistemological stance of contextual constructionism is considered in the context of phenomenology (interpretivism), using IPA to analyse and to make sense of the gathered data. The following two questions will be considered to evaluate the findings of this research study from the epistemological position taken: 1) *“Is there objective truth about what it is like working with people with borderline personality disorder and, if so, can we identify it with precision and understand it through an exploration of therapists’ experience?”* 2) *“Is therapist*

*experience independent of the already existing knowledge in the literature or do both their experience and existing knowledge contribute to the construction of their meaning making?"*



## 2:3 Methodology

### 2:3.1 Interpretative Phenomenological Analysis

The theoretical and philosophical underpinnings of IPA include phenomenology, hermeneutics and ideography. Firstly, IPA is phenomenological in the sense that it is interested in examining experience in its own terms and the significance of a particular lived experience in people's everyday lives (Smith *et al.*, 2009). Husserl (1927) argued that people should 'go back to the things themselves', need to be aware of the consequences of their taken-for-granted ways of living and they need to 'bracket' out the taken-for-granted worlds, in order to focus on their perception of that world. In contrast, Heidegger (1927/1962) was more interested in the ontological question of existence, the practical experiences and relationships people have, through which, he believed, people perceive the world and make meanings. Thus, IPA is concerned with how people are 'thrown into' a world of objects, relationships and language, and how their being-in-the-world is always 'in-relation-to' something. Merleau-Ponty (1962) argues that, while we can understand other people's experiences and empathise with another, we can never completely share those with them, since their experiences come from their own embodied position in the world. Finally, Sartre (1956) argues that 'existence comes before essence', which refers to his understanding that the self is always developing and that it is not a pre-existing unity to be discovered, but an ongoing project to be unfolded.

Secondly, IPA is informed by hermeneutics, the theory of interpretation. It is concerned with how people make sense of this experience. The ability to access their experience is dependent on what people tell the interviewer and how

the interviewer interprets that experience (Smith *et al.*, 2009). Thus, IPA is double hermeneutics, because the researcher is trying to make sense of the participant trying to make sense of their own experience. Schleiermacher (1838) offers an intersubjective dimension of the phenomenological approach, claiming that interpretation depends on sharing something with the person being interpreted, as “everyone carries a minimum of everybody else within themselves” (p. 92-93). Heidegger (1927/1962) argue that an access to ‘Dasein’ is always through interpretation and he explored the ‘thing itself’ as it appears, because it is related to deeper latent form, which it is both a ‘part of’ and ‘apart from’. Heidegger’s thinking is very closely connected with IPA, as it is an interpretative phenomenological approach.

Finally, IPA is ideographic, because it focuses on the study of the particular. It is concerned with the detailed examination of a certain case; what the experience of a particular person is like and what sense that person is making of what is happening to them. It involves a detailed exploration of both the similarities and differences of each case. IPA focuses on the particular on two levels. Firstly, the focus is on the detail, and thus the depth of analysis. Secondly, there is a focus on understanding how a particular phenomenon is understood by certain people in a certain context. Experience is very complex from a phenomenological view, because it is uniquely embodied, perspectival and situated, and thus it is similar to an idiographic approach. Furthermore, experience is also a relational phenomenon, as it is based on a world of objects and relationships.

In contrast with social constructivism, IPA places particular emphasis on the assumption that what people have to say about their experience reflects something about their inner world and that meaning is already established in a person's psychological make-up (Smith, 1996). This may have implications for the approach psychotherapists take towards working with clients with borderline personality disorder in psychodynamic settings, as therapists' pre-existing knowledge about what it is like working with this patient population may influence their way of working and, therefore, their meaning making of their experience. Because it is impossible to access pure experience, researchers try to get an 'experience close' study. While the researcher needs a close interpretative commitment to make sense of what the participant is saying, a careful approach to either 'bracketing' or being aware of one's preconceptions is also necessary.

### *2:3.1.i IPA and other approaches*

IPA is an integrative approach, with a focus on psychological, interpretative and ideographic components, which shares some overlap with other approaches. For instance, it is similar to Foucauldian discourse analysis in that it examines how people's worlds are discursively constructed and what the consequences of these are on the experiences of the individual (Eatough and Smith, 2006). However, the main focus in IPA is the lived experience of the individual, while considering the multiple influences on it in the light of its historical and cultural situatedness, including language, social norms and practices. For instance, an interview is a localized interaction, which informs the researcher about how an individual constructs a particular experience. However,

IPA acknowledges that this contingent contextual analysis is only a partial account of that experience, thus emphasising a degree of consistency between accounts, thoughts and actions and across interactions. Furthermore, it recognises that the narratives are also concerned with human potential and development and with connecting the past with the present and the future (Eatough and Smith, 2006).

An alternative method for IPA is grounded theory, as both have an inductivist approach to inquiry. However, IPA focuses more on the detailed analysis of the lived experience of a small number of participants with the aim of identifying convergences and divergences between them. On the other hand, the emphasis in a grounded theory study is on a more conceptual and explanatory level with a larger number of participants, and with the aim of drawing theories from individual accounts. Furthermore, thematic analysis and IPA are epistemologically similar because there is a focus on the descriptions and interpretations of individual subjective experiences. The major difference occurs between the analytic processes, for IPA uses notes and comments as opposed to the open coding strategy of thematic analysis and grounded theory (Braun and Clarke, 2006). Thus, IPA seemed a more appropriate choice for this study, because of the ideographic and subjective nature of the evaluation of a unique perspective of each individual's own life (Smith *et al.*, 2009).

### 2:3.2 Current issues for IPA

#### 2:3.2.i Assessing Validity

Validity can be defined as the extent to which a research study describes and measures or explains what it aims to describe and measure or explain (Willig, 2001). In qualitative research there is an assumption that the phenomenon under question has a 'reality' in an objective sense, which qualitative researchers reject. Instead, there is a focus on whose reality the study is exploring (Finlay, 2006). Thus, there are certain concerns about validity in qualitative methodologies. Firstly, in qualitative data collection participants may challenge and even correct the researcher's assumptions about the phenomena explored by the study. Feedback may also be obtained on the findings from participants and, if they make sense, the study must have some validity (Willig, 2001). Furthermore, qualitative data collection happens in real-life settings, such as through interviews, rather than in an artificial setting, such as the laboratory, so that the research can have higher ecological validity. Finally, reflexivity confirms that the research process is examined closely throughout and that the researcher is aware of their role in the research. This helps to prevent impositions of meaning by the researcher and therefore increases validity (Willig, 2001). It is understood that researcher objectivity is ideal rather than certain, so that there is an attempt to approach the meaning of the data without having any preconceptions or judgments and with an understanding that alternative interpretations are always possible.

### 2.3.2.ii Reliability

Reliability is the consistency of measure. A measurement is reliable if it produces the same results on different occasions under the same conditions with the same subjects. However, qualitative researchers are less interested in reliability, because the emphasis is on the investigation of a particular, possibly unique, phenomenon or experience in detail. In contrast to quantitative research, qualitative studies do not attempt to measure a certain attribute using a large number of participants (Willig, 2001). In a qualitative study, the researcher attempts to obtain data at a particular time and place and within a particular interpersonal context, although there are a few qualitative researchers (e.g. Silverman 1993), who argue that qualitative research methods, if applied appropriately and rigorously, might yield reliable results. Thus, when different researchers gather and analyze the data, using the same method, findings are the same regardless of who conducted the study (Willig, 2001). However, most qualitative researchers take the position that a study can never be replicated, even if the same researcher was to interview the same participant at a different time or place. This is because the same participant would not be able to tell the identical story twice, therefore the data would be different (Finlay, 2006). Qualitative research may also be assessed by supporting data interpretations with illustrative examples derived directly from the data set, so that readers can evaluate their reliability and plausibility (Elliott *et al.*, 1999; Dallos and Vetere, 2005).

### 2:3.2.iii Generalizability

In qualitative research, findings are not sought to be inferred from a specified sample to the wider population, but they might rather be transferred and have meaning if applied to other individuals, contexts or situations. Therefore, the richness and depth of data can be gained from just one participant (Finley, 2003). According to Willig (2001), IPA researchers acknowledge that experience is never directly accessible to the researcher, but always depends on the story of the participants, which will be interpreted, in order to make sense of it. Thus, it is not possible to draw definite conclusions about why their experience is as it is. Willig (2001) argues that acceptance of such limitations helps reflexive thinking and recognition of the boundaries of claims to knowledge and understanding. Furthermore, as different qualitative research methods are understood from different epistemological positions, it is not always possible to generalize their findings. However it might be that if ‘a given experience is possible, it is also subject to universalisation’ (Haug, 1987, p. 44). Since a small number of people took part in this study, generalizability can be achieved through theoretical generalizability, where the reader is able to assess the outcome of the research in comparison with their existing professional and experiential knowledge (Smith *et al.*, 2009).

### 2:3.2.iv The quality of qualitative research as evaluation criteria

Qualitative research criteria encourage researchers to address specific qualities of a study, to investigate the greater impact and social relevance of a

particular project and to explore both strengths and weaknesses (Finlay, 2006). The evaluation of qualitative studies can best be achieved through evaluating its qualities in accordance with its underlying epistemological position. Yardley (2000) put forward four broad principles for evaluating the quality of qualitative studies, which this study selected for its criteria for evaluation. First, sensitivity to context is vital, which researchers show in the early stages of the research through a focus on the idiographic and the particular. It may also be demonstrated by engaging with the data in the interview, while expressing empathy by considering the participant and their needs, becoming aware of interactional difficulties, and negotiating the powerplay between the researcher and the participant. Yardley (2000) argues that the data is the strongest context, to which the researcher may become the most sensitive. Another way to show sensitivity is through being aware of the existing literature, with which the findings should be connected.

The second broad principle is commitment and rigour. The researcher may show commitment by being caring about the participant in the interview process and by paying close attention to the analysis of the data. Thus, an expression of commitment can be similar to an expression of sensitivity to context. Rigour can be demonstrated by the thoroughness of the study, such as suitability and homogeneity of the sample, the quality of and consistency through out the interview, and the thorough and systematic completeness of the analysis with good idiographic engagement and adequate interpretation.



The third broad principle for assessing quality is transparency and coherence. Good transparency is achieved when the stages of the research process are described in a clear way to the reader. Coherence refers to the degree to which the study is written up in a coherent, careful and comprehensive way. According to Yardley, a consistency between the research findings and the underlying theoretical assumptions of the approach can also demonstrate coherence.

Finally, the fourth broad principle is impact and importance, where validity of the study can be assessed by conveying something interesting, important and useful to the audience. Since IPA is a creative process, the application of validity must be flexible, as what may be adequate for one study may not be so for another (Smith *et al.*, 2009).

### 2:3.2.v Reflexivity

Qualitative research recognises that the researcher has a direct effect on the research process, both as a person (*personal reflexivity*) and as a theorist or thinker (*epistemological reflexivity*, Willig, 2001). In qualitative research, reflexivity needs to be considered, in order to encourage the researcher to reflect upon the ways in which the person of the researcher is involved in the study and its findings. Reflexivity allows the researcher to think about how their own reactions and personal biases to the research context and the data invite particular insights and understandings. According to Willig (2001), this process is similar to the concept of countertransference, the therapist's own reaction to

the client, in psysychoanalytic therapy, so that a better understanding of the client is facilitated. Thus, as the research process influences the object of inquiry, the role of the researcher needs to be acknowledged in the process of the research (Henwood and Pidgeon's (1992).

In qualitative research, the evaluation criteria must be consistent with the epistemological framework of the research. Willig (2001) maintains that while studies from a contextual constructionist epistemological viewpoint can show the relationship between accounts and the contexts within which they have been produced, the application of evaluative criteria, addressing the relationship between the phenomenon and the conditions, may not be validated. For instance, an interpretative phenomenological study might not be interested in such a relationship. Those studies which are not concerned with that relationship focus on a meaning in context, with an emphasis on hermeneutic interpretation, and address reflexivity issues in an attempt to acknowledge and demonstrate how the study has been constructed by the researcher's perspective and position. Thus, the present study focuses on the meaning of the participants' accounts in context, with an emphasis on hermeneutic interpretation, and reflexivity as a method for evaluation, rather than the relationship between accounts and context. While, using these methods may not account for the phenomena, they may explain a comprehensive description of the phenomenon studied (Willig, 2001).

## Chapter Three: Analysis and Results

### 3:1 Analysis

#### 3:1.1 Processes and strategies for data analysis

IPA is not a prescriptive approach. Instead, it is a set of flexible guidelines, which can be adapted by individual researchers, on the basis of their research aims (Smith and Osborn, 2003). Thus, the procedure adopted in this study, involved treating the interviews as one set of data. Smith and Osborn (2003) developed several stages to analyse the interview material, which were followed.

*Looking for themes in the first case.* This stage involved reading the scripts several times and looking for ‘similarities, differences, echoes, amplifications and contradictions in what a person is saying’ (p.67). The researcher’s role was to feel more ‘wrapped up’ in the data, becoming more responsive to what was being said. The left-hand margin was used to make comments on anything that seemed interesting and important. The right-hand margin was used to transform initial notes into more specific themes, using psychological concepts while taking care not to lose the connection between the participant’s own words and the researcher’s interpretations.

*Connecting the themes.* This stage consisted of further reducing the data by building connections between the emergent themes and clustering them accordingly. These clusters were then given a descriptive label (‘sub-themes’ for lower-order themes and ‘super-ordinate themes’ for higher-order themes), which conveys the conceptual nature of the themes.

*Continuing the analysis with other cases.* This involved incorporation from other interviews, in order to establish how views were similar and different. According to Smith *et al.* (2009), a super-ordinate theme must occur in ‘at least a third, or a half, or, most stringently, in all of the participants interviews’ (p. 107) to be classified as recurrent. Furthermore, they argue that the super-ordinate theme may be manifested differently in different themes; and the same theme or super-ordinate theme may look different across different accounts. Thus, a balance between divergence and convergence, commonality and individuality needs to be constantly negotiated. A table and a list of master themes and super-ordinate themes were constructed (Table 2). An illustrative data extract is shown alongside each theme, followed by the line number, to allow the researcher to return to the transcript and check the extract in context (Appendix 8). Eatough and Smith (2006) suggest that ‘for the researcher, this table is the outcome of an iterative process in which they have moved back and forth between the various analytic stages ensuring that the integrity of what the participant said has been maintained as far as possible. If the researcher has succeeded, then it should be possible for someone else to follow the analytic journey from the raw data through to the end table’ (p. 120).

*Write up.* This stage involved translating the super-ordinate themes into a narrative account and providing a ‘results & analysis’ section. Here, IPA involves examining each interview in a step-wise analysis fashion, and comparing it with the others. The main focus was on the participants’ thinking, feeling, speaking, physical bodies and the relationship between these (Smith and Osborn, 2003). As the experience of the participants is yet unknown to the researcher, it seems more exciting and meaningful to listen to their experience

and the meaning they assign to it, using this qualitative method. Enough data should be presented for the reader to be able to assess the pertinence of interpretations.

Analysis of the data established five master themes, which attempted to describe the participants' lived experiences of working with people who have borderline personality disorder. All of the master themes, and their interrelated super-ordinate themes comprising it, are reported here. They present how each individual made sense of their experience as a psychodynamic therapist. All names in the paper have been changed to safeguard confidentiality.

## Results

**Table 2: The five master themes and their interrelated super-ordinate themes**

**Master theme 1: Negative countertransference**

- 1) *Hopelessness*
- 2) *Inadequacy*
- 3) *Difficulty in containing feelings*
- 4) *Therapists' cognitive abilities affected*

**Master theme 2: "Sitting in the dark together"**

- 1) *Bond between therapist and patient*
- 2) *Significance of 'Being' rather than 'Doing'*
- 3) *New experience as template for relating*
- 4) *Empathy is crucial*

**Master theme 3: Hindrance in therapeutic work**

- 1) *Significance of modifying the psychodynamic model*
- 2) *Difficulty in accessing empathy*
- 3) *Interpretations as unbearable*
- 4) *Therapeutic relationship is threatening*

**Master theme 4: Therapist omnipotence**

- 1) *Power of therapist*
- 2) *Ability to survive the patient*
- 3) *Self-importance as therapist*
- 4) *Capacity to contain the patient*

**Master theme 5: Labelling as problematic**

- 1) *BPD label is rejected by patients*
- 2) *Label is helpful but unhelpful*
- 3) *Questioning the validity of diagnosis*
- 4) *Label reinforces psychopathology*

### 3:2.1 Master themes<sup>11</sup>

This section reports on five master themes derived from the process of analysis in this study: *Negative countertransference*; *"Sitting in the dark together"*; *Hindrance of therapeutic work*; *Therapist omnipotence*; and

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<sup>11</sup> See 'Appendix 8' for all the master themes and their super-ordinate themes- including an illustrative extract for each theme and their line number/s.

*Labelling as problematic.* All therapists' patients will be referred to as 'she', in order to protect the therapist and their patients' identity. Some therapists worked with only one borderline client, and thus referred to only that particular client throughout the two interviews. Those therapists, who had experience with more clients, described their experience with reference to all of their clients in general. However, at times they gave specific examples with reference to a certain client. None of the therapists revealed their patients' identity, due to confidentiality.<sup>12</sup> While all therapists experienced most of the themes reported in this study, some of the themes were not described by all of them.<sup>13</sup> Direct quotes from participants' accounts are written in italics. An extract of a full transcript of one of the interviews is provided as an example in Appendix 9.

### 3:2.1.i Negative countertransference

First, therapists' accounts of negative countertransference experiences are presented. *Countertransference* is therapists' reaction to patients' transference of feelings, thoughts and attitudes from past relationships onto the relationship with the therapist. This master theme represents four super-ordinate themes that the process of analysis revealed: *Hopelessness; Inadequacy; Difficulty in containing feelings; and Therapists' cognitive abilities affected.* The analysis is introduced by a few extracts, which present some of the main features of participants' experiences of hopelessness, a common negative countertransference feeling.

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<sup>12</sup> See 'Table 1' for a summary of the therapists' experience in section 2:1.2 on page 46.

<sup>13</sup> See a more detailed explanation of this in section 3:1.1 on page 67, in the paragraph beginning with '*Continuing the analysis with other cases*'.

They vividly illustrate how therapists seemed to feel trapped in despair due to their fear that things would not get better for their patients.

*“Mmmm... I feel... hopelessness...uhmm...quite a kind of nihilistic sort of despair...not...not a sadness... a kind of despair that...this matters would really, I suppose, would improve for the client.” (Maria)*

*“I think... it’s also this type of work is often a little bit hopeless. Because you’re getting into the... [sigh]... the real despair... and their loss. And I think, you know...that bit tends to get a bit hopeless... but often they do go away with something, you know...” (Melanie)*

*“There’s helplessness and hopelessness, you know, validating how she feels, which she can’t stand she absolutely finds it as completely horrible... It does sort of feel very much like bringing somebody up, trying to make them to be a different person... by just telling them how to be.” (Agnes)*

In the above passages, both Maria and Melanie drew on the effect of despair, as narrative resources, to make sense of their feelings of hopelessness in their work with borderline individuals. It appears that feelings of despair and hopelessness may not be too uncommon emotive reactions among therapists, which is clearly demonstrated by Melanie’s account. Here, she tentatively suggested that working with this patient population was naturally and inevitably hopeless for her. At the same time, she conveyed the idea that her patients had in fact gained something from therapy, which appears to be in contrast with other



participants' beliefs. For instance, in the above extract, Agnes experienced her patient as a hopeless child, who was not able to benefit from therapy. This feeling seemed to have left Agnes feeling hopeless as well as frustrated.

The notion of hopelessness implicitly draws on the next theme, inadequacy, therapists' feelings of 'not being good enough', which was another commonly shared countertransference feeling. These feelings, of therapists' inability to help their patients, imply a lack of confidence and insecurity on the therapists' part, and could therefore have led to their feelings of hopelessness. In the following passage, Helen's inadequate feelings seem to be induced by her patient's criticisms of her. Thus, a plausible interpretation of her experience may be that her inadequacy was generated by her patient's view of her, as a therapist. For Helen, supervision was necessary to restore her confidence and to encourage her to continue working with her patient.

*"Well... I go to my supervisor...which is very very helpful...it always puts me to a place of my own insecurity, as a therapist....because often that's been thrown at me that I've been unprofessional, useless and I've done this wrong and that wrong. So, uhmmm...for me, my supervisor, in a sense, is normalising and being very...uhmmm...I tend to say supportive...uhmmm...the normalising, I think, is the most important thing...that there wasn't something, well not with me, I wasn't a bad therapist...uhmmm...help me move to...to somewhere...I guess, you know, it was running its course." (Helen)*

It appears that Helen placed a great significance on feeling that she was a capable therapist, in order to help her patient. She used the word ‘normalising’, which left the researcher wondering whether Helen was afraid of becoming like her patient, whose diagnosis may have suggested some sort of abnormality about her for Helen. Similarly, Melanie also described her own need to be a ‘saviour’ and to be the ‘best’ therapist she could be for her client. However, this desire seems to be threatened by her fear that she may not have been valued by her patient as much as she wished she would be, regardless of what she did. She appeared to be fluent with the psychodynamic vocabulary during the interview, as she often referred to her feelings as her ‘countertransference’ feelings. The repeated use of the word ‘you know’ gave the impression that Melanie tried to reassure the researcher that her feelings were indeed a countertransference feelings. This might have also been related to her lack of confidence as a psychotherapist.

*“I think I feel like ‘Yeah, I might be up to the task’, but, you know, when my own countertransference kicks in, you know, my own kind of wanting to be the best, you know, wanting to be the one person who does it... so, it also kind of gets me going as well, I wanna be the saviour... uhm... but, then I also, on the other hand, I get the fear that I’m not good enough. Because in my experience of borderlines is that... no matter how much good they get later on it’s not quite enough.” (Melanie)*

As with Melanie, in the next extract some weight was given to the recognition of countertransference feelings by Agnes, who explained her

inadequacy as borderline patients ‘doing it to her’. Her narrative conveys a sense that without her awareness of her countertransference she would not have confidence in herself, as a therapist, making her work extremely difficult with these patients.

*“I suppose I... I suppose it just makes you feel inadequate and that you are not giving...that you are not the right kind of therapist, you are not being any good for them... you’re wasting that time. I think it just... I think that it just undermines... it just undermines the work, because you... you... feel so powerless and that’s something borderline people do to you... to make you feel completely useless. So, that’s really important that you’re aware of your countertransference, because otherwise you just think that you’re a bad therapist.” (Agnes)*

While only some therapists described characteristics, such as having hope and being an adequate therapist, as significant attributes for working with borderline clients, all therapists reflected on their difficulty in containing certain feelings, which they experienced in therapy with their patients. All of these accounts very powerfully convey what it might be like for a therapist working with someone who has BPD. The researcher was struck by a strong common thread in several accounts and by how similar their meaning seemed to be for each participant. For instance, Leah says:

*“What she makes me experience, I think she subjects me to... uhm... such tirades, such horrible experiences, sometimes of being at the receiving end of*

*someone, who is very overwhelming and intrusive, and swears and pushes me, knows even that sometimes she is pushing me, I know that she wants me to feel the kind of... feel hurt by the way she is speaking to me. Uhmmm... and it takes all my strength sometimes not to just say 'Sorry, I really don't think I can help you'. Uhmm... it's so hard to be with her.. and when she goes into these states, she physically changes, the way she looks, the way she speak. She becomes like a grotesque figure that's really quite frightening."* (Leah)

In the above passage, Leah drew on the significance of having personal strength and commitment as a therapist to work with borderline individuals. She attributed some power to her patient when she said 'she makes me experience' and 'she subjects me to... such horrible experiences', as if she was her victim. It seems that her patient's conscious awareness of the effect of her behaviour on Leah may have sometimes left Leah feeling on the verge of giving up working with her. In the following passage, Maria's experience also reinforces the significance of personal strength to tolerate and contain her feelings, evoking a sense of need for survival. In addition, in the second extract, Helen's use of the metaphor 'I am receiving the gunshots, but I'm also rendered sort of speechless' is another powerful indicator signifying this need for therapist survival.

*"...Sometimes quite profoundly, because it's very... I'd say I can feel quite killed off by them... so, trying to think in the room when somebody is trying to obliterate you is... is... it can be really hard...and it...it can be really...very physically tiring. So, it definitely is how a lot of them... thinking about the work*

*reflectively...is often... how you can withstand them or how can you... find it... to bring something into that.” (Maria)*

*“I feel...uhmmm...well, I think I go numb, actually...in the sense of protecting myself...I...yes...yes...I am receiving the gunshots but I’m also rendered sort of speechless...don’t know what to say...uhmmm...so, I just, I try and not express anger with her, I try not to retort, but I think for me, it’s... I always go into my ‘I need to survive mode’. Uhmmm.. Well, in the session, I think, part of me steps out, probably out of the room...and it’s slightly like holding my breath...or...for the entire session.” (Helen)*

A point of interest in Helen’s account is how her attempt to gain control of her anger, and disconnect from the patient, in order to protect herself, promoted her survival. In contrast to Helen, other therapists did not feel as able to contain their negative feelings. For instance, Agnes felt that her patient subjected her to horrible experiences, which she found almost impossible to cope with. The hesitant repetitions of ‘panic’ and ‘awful’ emphasise Agnes’s struggle for survival, as well as her fear that she might not do. Her reference to the notion of countertransference carries some weight of being the victim of her patient in their relationship.

*“....When she starts talking about him and how he is behaving and what she’s trying to do, I panic. That’s how, that’s the emotion she really puts into me, I can feel my heart racing, I feel very very panicky, because I think this situation is so awful and he [the patient’s partner] is so awful and what she’s describing is*

*so awful, I don't know what to do. And I get really anxious about that to the point of panic....now I make an effort not to have him in the room, because I can't cope with him.. And that's obviously a countertransference, that's another... that's her again."* (Agnes)

Finally, negative countertransference also seemed to affect therapist's cognitive abilities in therapy. This may be best demonstrated by the researcher's experience of one of the participants, who, during the process of the first interview, seemed to be less and less able to recollect a comprehensive account of her experience, and to express herself. In the second interview, the researcher reflected on her experience of what had happened in the first interview, and a parallel process between the participant's experience of her patient and the researcher's experience of the participant was mutually identified. This experience exceeded the dual role of the researcher, whereby the researcher was trying to make sense of the participant trying to make sense of her experience. Here the researcher could experience the participant's experience of her patient first-hand. As if the therapist' cognitive abilities, who 'became' her own patient, were affected in such a way that she slowly started to stop functioning. In turn, the researcher's mind was also affected by Maria's emotional engagement with her experience. The extract below provides an example of her experience of the patient.

*"...she was draining because she just...her mind was like a blank. I found it really, really hard to...to literally have images and thoughts in my own mind when I was in the room with her... uhm....so, she was...I felt sort of...sort of*

*weighed down by her.. so, I'm flat..... I find the best thing for me working with borderline people is always to...to get help actually...from my supervisor or my peer group...because I find them the most difficult people to think about and to think of what they're doing to me and all of that...it's very difficult to think about on your own."* (Maria)

Another two therapists also reflected on their difficulty in thinking of their patient and remembering details of the sessions. For instance, Leah referred to her experience as something that 'scrambled her mind'. This strong metaphor offers an understanding of a process, where her mind was scrambled like an egg that was transformed from a solid entity into something messy and frail.

*"... and there were particular other experiences I had in the first meeting with him, like the difficulty of remembering what happened in the meeting... I would call that a countertransference phenomenon, whereby the impact that he had on me, which was to rather scramble my mind. It's a fear with the usual functioning of my mind.... It alerts me also that someone has had a particular impact on my mind and that I find it particularly difficult to remember... uhm..."* (Leah)

In summary, the above narratives of therapists' experience of negative countertransference feelings demonstrate their retrospective awareness of their reactions to their patients in psychotherapy. Not only did they seem to feel hopeless and inadequate, but they also seemed to lose some of their capacity to contain their own feelings, and thus cognitively function, as a result.

### 3:2.1.ii *“Sitting in the dark together”*<sup>14</sup>

This master theme represents four super-ordinate that the process of analysis revealed: *Bond between therapist and patient; Significance of ‘being’ rather than ‘doing’; New experience as template for relating; and Empathy is crucial.* They may encapsulate what happens between therapist and patient in the room and their significance for therapists during their work with borderline clients. The following two extracts illustrate how a bond, based on therapists’ efforts to show that they care about their patients, can make a significant difference in patients’ feelings and attitude towards the therapist and thus therapy itself.

*“I think it’s...we call it... a deep connection and it can be something very small that will cause quite a big change..... I’ve seen this borderline person recently always acting out... and then in one session she just said something about her sister ‘She’s like this and that’ and I said ‘Well, you may feel that but I actually hear her saying that she’s protective that she wants to protect you...sounds like it’s from a caring position.’ And, that’s it, from then on, literally that one sentence and she has...it’s completely changed the relationship... And, I’m thinking ‘Huh? How did this happen?’” (Melanie)*

*“I’m just thinking of something that I’ve recently had to do...and how...many of the more borderline patients could stay away and...you know, after he was absent for three sessions, I write a letter saying, you know... ‘Since*

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<sup>14</sup> This phrase was expressed by one of the participants, which both encompasses the inter-related super-ordinate themes within this master theme and refers to the ‘therapeutic relationship’ in a more idiographic fashion.



*you've not been able to attend since my cancellation on such and such day and I hope you... I'll see you on Friday', kind of thing... And he came back and said 'I'm here because of your letter. I didn't expect such a letter.... Yes, I certainly think this is how the process strengthened...the sense of alliance with this particular patient.' (Leah)*

Both of these accounts seem to imply that the establishment of a good relationship between the therapist and patient may be crucial for working with this vulnerable group of individuals. Melanie sounded surprised and moved by her patient's reaction to her suggestion that someone could care about her, while she also expressed care for the patient herself. Likewise, Leah's description not only conveyed the significance of a deep connection between her and her borderline patients, but it also suggested that without such connection the work could not possibly have progressed any further. While it should not be taken to mean that the meaning of relationship is exclusive to working with this type of patient population, it appears that it may be more significant for them in the context of their difficulties. Thus, this notion is further elucidated by the importance of 'being with' the client, as opposed to 'doing something to' the client in therapy, which is illustrated by the following passages.

*"Uhhmm...but there's something with this client that has... at some level I've let go of 'I must get it right and do it...'. You know, I must come up with the interpretation that's going to change... I very much just sit and sometimes I do reflect back. So, I... for me, it's really... I don't really try to change anything, I just try to be with." (Helen)*

*“Because we certainly don’t focus on the symptoms more directly...you know, we...we...the symptoms often improve through the process. We don’t focus on the symptoms. We focus on the emotional process that’s developing with the patient between therapist and the patient.” (Leah)*

In the first instance, while Helen felt that being with the client was fundamental to giving interpretations, despite the nature of the psychodynamic work, her account also gives rise to a feeling of hopelessness, earlier theme described, by claiming that she had let go of trying ‘to get it right’. In the next example, Leah, like other therapists, gave the impression that she valued her work as a psychodynamic therapist, where the focus was on the emotional relationship between her and her patient, as opposed to more symptom-focused modalities, which might place less value on this factor. Yet again, in the following narrative, Melanie’s use of the metaphor ‘sit with you in the dark, rather than trying to push you out of the dark’ provides a more in-depth and moving account of borderline patients’ need to be ‘held’ by their therapist in their pain, through a deep connection in the relationship.

*“...Uhhh..... uhhh.. it’s that connection that matters more than anything else. Somebody being able to sit with you in the dark, rather than trying to push you out of the dark, I think that’s... that’s what I find helpful. If that makes sense.” (Melanie)*

Thus, a bond between the therapist and client, with a focus on relating to the human being, as opposed to treating the disorder, appeared to provide

patients with a new experience that may have been most helpful to them in the context of their problems. Maria offered a lucid explanation for this interpretation. From her account, an understanding that borderline patients can find it difficult to maintain good relationships can be discerned. Thus, a good therapeutic relationship, as a new experience, is likely to enhance their relationships outside the room in different areas of their life. In addition, Helen's extract reveals that patients' experience of the therapist, both good and bad, may be therapeutic enough for them in the light of how they relate to both other people and themselves.

*"I suppose I'd say that the relationship is about...it's about enabling them to realise that there are relationships...to be that in the world, as opposed to a sort of fractured, isolated kind of understanding of that. Uhhh... and actually to contain them, so that they can function in society because, obviously, they do kind of have problems with employment and other people and... yeah."*  
(Maria)

*"I think if she can accept me when I made a mistake then...yeah, that's absolutely crucial....Absolutely crucial. Not only, because of her experience of other people, but because of her experience of herself. You know, she's either useless, or she's...perfect. It's modelling it in a way, yeah."* (Helen)

The researcher was struck by the similarities between the above and the next extracts, taken from Leah, which also attribute meaning to the significance of a change in patients' pattern of relating, through the relationship with the

therapist. Furthermore, in the final extract, Melanie's narrative provides yet further evidence for this theme. Here, although she spoke about her uncertainty about the treatability of BPD, she expressed no doubt that a good experience in therapy, as opposed to abusive and unboundaried relationships, could greatly benefit patients.

*"I suppose, in another aspect what they come to learn is that I'm not perfect. I don't get things right all the time, I don't...you know...I do misunderstand them sometimes or...and that...that is also a part of the process of...what...it's quite an important part of what they might learn from the process, to be less harsh with themselves." (Leah)*

*"But clients I've seen, they do go away with something. I think their experience of a good relationship I think and an attachment where, which hasn't been abusive, which had been boundaried, has been caring uhhh,... which has been a good ending.... I just think having another experience itself is helpful....so I don't know if you can treat it as such. But I think you can give a better experience." (Melanie)*

Unsurprisingly, the final super-ordinate theme 'empathy is crucial' is related to the previous themes, without which a good relationship would not be impossible. This theme is dominated by accounts of therapists' lived experience of empathy in its deepest form, 'projective identification'<sup>15</sup> (Leah's words). Through this process, both Agnes and Leah appeared to identify with the

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<sup>15</sup> Projective identification is when the therapist identifies with the patient's projection of their feelings, attitudes and behaviour in the transference relationship (Klein, 1946).

projections of their patients' unwanted and unbearable feelings, allowing them to 'practically experience the patients themselves' and really feel 'what it might be like to be them'. The two passages below illustrate this well.

*"...I think when you...you know that what's... that's happening to you is what...it's her, it can make...it can only enhance your understanding what it's like to be in her head, because you're practically experiencing it yourself. You know, it's really making the experience of being her incredibly real. I am not just empathising with her... I'm experiencing her." (Agnes)*

*"Uhhmm... of course, there're all kinds of ways, in which your patient gets you to know what it's like to be them,... the telling that comes to mind first, but there are other ways of getting you to know that... some of which are much more unconscious processes, we call them projective...call it projective identification, where the patient puts you the therapist, in the position of...of in a way, a position they were in, maybe, as a child. I really get to know what it's like to be this patient. So, that's how...empathy is, I think, that it's about knowing all that and it takes time to process your feelings enough to find a position, form which you can talk to the patient about.. in a way, you're talking about your own experience, if you've empathised in this deep way." (Leah)*

Elsewhere, Leah offered a further explanation for how unpleasant feelings, through the mechanism of 'projective identification', contributed to her experience of empathy in her work with borderline clients. The use of

psychodynamic terminology, in both of Leah's extracts, may inevitably enhance her understanding of the meaning of her experience.

*“But often it’s not like that, it’s more unconscious projections of certain feelings that they feel are intolerable. In a way, I think it’s part of the process of empathy, in a way.. See, I don’t connect empathy so much with positive feelings necessarily...maybe, most people do... I think part of empathic response does mean that I have to be open to experiencing feelings that are really unpleasant.”*  
(Leah)

In sum, it seems that therapists felt that the therapeutic relationship, and the way it affected therapy, through factors such as bond, being with clients and empathy, provided a new and hopefully better experience for their clients, which was necessary for therapeutic change.

### *3:2.1.iii Hindrance in therapeutic work*

This master theme describes certain obstacles, which therapists reported to have had in their work. Its super-ordinate are the following: *Significance of modifying the psychodynamic model; Difficulty in accessing empathy; Interpretations as unbearable; and Therapeutic relationship as threatening.* First, the process of analysis revealed that, although each therapist worked within the psychodynamic framework, most therapists felt strongly that there was a need for the modification of the psychodynamic model when working with these individuals. The opening sentence in the following passage provides a clear

demonstration for this claim. Here, Agnes offered her understanding that borderline patients may have found the psychodynamic model difficult to tolerate and thus required an approach which was more supportive and educational; this was the result of the patients' lack of insight in understanding interpretations.

*"...although in theory it's the psychodynamic model, in practical terms I feel as if I've been made into something that's quite concrete and am having to think of ways to explain things to her...which you wouldn't do with a psychodynamic person. You'd just be able to think about the feeling...I explain a lot about emotions... I change my style as much as I'm not very interpretative and I'm quite concrete. Yes, I do change my style, yeah." (Agnes)*

Further evidence as to why patients might need some education within the psychodynamic modality comes from Helen's narrative below. She said:

*"I mean, you know, we did a bit of education about trauma and how you carry stuff and it takes you back...uhmm...and gave her things about...you know, separating out...to get some understanding about what her reaction was to do with past experiences. ... it was like giving her a gift...to...to...to think about it in a different way." (Helen)*

Thus, it appears that patients may have tolerated the psychodynamic model more effectively when therapists provided cognitive explanations for them during the process of therapy. Similarly, Maria argued that the input of cognitive

elements in therapy may not only have been necessary to enhance patients' understanding, but they were also crucial for helping them to stay in therapy. Thus, it could be that because of patients' difficulties in withstanding painful feelings evoked in therapy, therapists also needed to offer them a safe and supportive environment. Melanie's account supports this view, for it was her experience that more supportive techniques were more beneficial for borderline patients than the more traditionally structured psychodynamic approach. In addition, the researcher got the sense that her phrase 'seeing the whole of you' meant that the psychodynamic model is more likely to focus on patients' 'pathological' aspects, whereas she found that a focus on the whole of a patient's personality, including more functional parts, was vital to help them tolerate their negative experiences.

*"...I think probably it's worth kind of, at the beginning of the work, kind of...you know, trying to put in something quite cognitive, if you like, to encourage positive transference. Because if you allow yourself just to be set up in a negative...so, I don't see the point in that. Because then the person will leave very quickly. There's a lot of that. So, speaking to that sort of bit, if you like, speaking to that part of them that wants something different." (Maria)*

*"I think psychoanalytic work can, I know... working on the negative, but you also need to work on the positive...particularly for a vulnerable group... you know, you've to have a particular strength to always keep going on about the negative experiences, the negative everything... It's the supportive element but also seeing the whole of you.." (Melanie)*



Thus, it appears that the need for supportive elements within the psychodynamic model implicitly called for empathy. However, a paradox emerged in the data analysis, indicating that at times therapists found it difficult to access empathy. In the following two illustrations, there is an immediate sense that the therapists' difficulty in accessing empathy may have been a result of their negative countertransference feelings. All participants shared this understanding, two of which are presented here.

*"Well, empathy is much more difficult when there are negative CT feelings...then, it depends on the degree of negative transference...uhmmm..."*  
(Maria)

*"I think the loss of empathy is the counter-transference reaction there, yeah.... I suppose because I wasn't empathising with her, I couldn't be aware of what was going on for her. So, it was really a loss of connection. It was a real kind of broken connection there."* (Agnes)

While Agnes felt that a lack of empathy affected her connection with her patient, the extract from Helen below reveals a sense of 'normalisation' of her loss of empathy for the client, through relating it to relationships in general. This was reflected in the way she explained that having no empathy might be a natural process characteristic of most 'real' relationships. An alternative meaning that might be attributed to this passage is that a lack of empathy subjected the therapeutic relationship to a 'make or break point'. If both therapist and client

survived this phase, the bond between therapist and client may have become stronger.

*“Well, I think it stifles all the potential creativity in fact... and I also believe that there are maybe...maybe phases when you’ve to just hold your breath and...little time...well, there’s no real empathy. You’ve to just hold your breath and hang on in there...uhmmm...in a way, that’s how relationships are, aren’t they? There are periods in any relationships, anywhere, where things are going really badly and do you walk out or do you hang in... in there and something on the edge softens and you can begin to work again.” (Helen)*

Another hindrance in the work with borderline patients within the psychodynamic model was patients’ difficulty in tolerating interpretations. This notion is elucidated by Agnes’s narrative in which her description of her patient behaving as a toddler saying ‘No, no, no..’ draws on images of a crying and vulnerable child, who has just been punished by a persecutory parent. However, the therapist’s firm and strong voice evoked images of an angry person, in the researcher, who was defending against something painful. Agnes’s experience that her patient found interpretations unbearable and ‘attacking’ was also shared by Maria.

*“Because, they would find...they find interpretations so persecutory, I can not make interpretation... she simply can’t bear it. I never...sometimes I try an interpretation and she becomes like a toddler and she just says ‘No, no,*

*no... '... suggesting that something is going on for her that's intolerable."*  
*(Agnes)*

*"....I think some of the interpretations can be quite attacking, and I think they probably tend to be better off, because of the kind of...the weight of what's going on..." (Maria)*

In contrast to other participants' experience, Helen felt that at times patients did indeed benefit from her interpretations. Her metaphor 'gobbles them up' not only depicts borderline individuals' struggle with tolerating these painful hypothetical statements, but also implies their acceptance of them through the process of quickly swallowing them as if they were afraid that the therapist might take them back.

*"I'm not somebody who, I think, gives a lot of interpretations anyway, but, yes, I think I... sometimes she uses them, she gobbles them up, as it were, and other times it's absolutely the wrong time to do that.... Occasionally I think about these interpretations I do give... and she sometimes, she...it's so helpful to her, well, it's so helpful to her in the moment, because I probably give it to her not when she's the most angry...uhmmm... So, what I don't know is how much she can use those in those bad patches, but there's certainly sometimes just the simplest thing that she's never thought of or never looked at that way... I can't think of an example, but..." (Helen)*

Another point of interest in Helen's account is the suggestion that perhaps it was not the interpretations themselves, which this borderline patient found unbearable, but rather the timing of interpretations. Thus, it might be that the interpretations were more helpful at the time when borderline individuals had more capacity for engaging with them emotionally. Further evidence for this assumption comes from the extract from Maria below.

*“I think it's very threatening to...to be very here... and now sort of interpretations and so...I prefer to...when I am making sort of interpretations that I think would be quite shameful, quite exposing to somebody, I like to do it later. I like to do it when we moved away from that moment...particularly with this sort of patient group....” (Maria)*

Thus, it might be that a lack of empathy and the bad timing of interpretations within psychodynamic therapy threaten the therapeutic relationship. Moreover, and perhaps not surprisingly, most therapists' reflection on their experience led to the assumption that borderline patients can find closeness difficult, despite their need for having a close relationship. Melanie's narrative below is a possible explanation for this finding. Following this, Agnes's narrative carries some sadness, while she expresses a lot of empathy for her patient. The 'pain' she referred to could be understood in terms of the patient 'being in pain' in the phenomenological sense, which the therapist experienced with her in the room and, which the researcher also had a sense of during the interview.

*“It’s all about borderline, the kind of wanting the intimacy but also finding it too much. It’s kind of....it’s probably their fear and phobia of abandonment. If you get too close to somebody they get too close for you to feel overwhelmed, it’ll be too much or you can be completely terrified that they abandon you.” (Melanie)*

*“....it’s just having that connection feels intolerable because it’s such a reflection of her vulnerability and her hurt. I think saying that you are in pain it’s one thing, but having someone else saying it...it’s completely different. I don’t think she ever had that experience...she finds it very very hard.” (Agnes)*

Finally, in the next two poignant pieces of data, a weakness in the working alliance emerges as another difficulty, as a result of patients’ perception of the therapeutic relationship as being threatening, which both Maria and Leah found challenging. According to Maria, while the psychodynamic way of working naturally constructed a relationship with her patient, she found the quality of the relationship (working alliance) weak. Furthermore, the extract from Leah gives the impression that the alliance was an important factor in her work and she describes how patients might be encouraged to establish it.

*“I think that actually the structure of the work may make it look as if they’ve got more of the relationship than they have.... But I think, what you probably don’t feel...what I probably don’t feel is that you’re really sure of what I call the working alliance. In the same way that I might be with somebody who is healthier.” (Maria)*

*“In a way, I suppose, it needs to be possible to establish some kind of alliance and often with borderline patients, you also might need help from other parties involved in the case to help them get back to therapy. You can...you know, sometimes particularly, maybe more borderline...more disturbed patients...they might need some external help to get back to the therapeutic situation, because their capacity maybe to... to form an alliance is weak.”*  
(Leah)

To sum it up, there are various factors which might affect therapists’ ability to work with borderline patients in psychodynamic psychotherapy. The analysis revealed that four of these factors were therapists’ difficulty in working strictly within the psychodynamic modality and their inability at times to access empathy, and patients’ difficulty in tolerating transference interpretations and in establishing a close relationship with their therapist.

### 3:2.1.iv Therapist omnipotence<sup>16</sup>

Therapists’ feeling of superiority and power within therapy came across as a significant factor during the analysis of the data, contributing to the fourth super-ordinate theme: therapist omnipotence. This master theme consists of four super-ordinate themes: *Power of the therapist; Ability to survive the patient; Therapist’s self-importance; and Capacity to contain the patient.*

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<sup>16</sup> ‘Omnipotence’ here is the researcher’s own choice of words; it is a reference to the therapists’ ability to work with “difficult” borderline patients and to ‘heal’ them within the context of psychotherapy.

Therapists assumed an active and somewhat powerful role, which was reflected in this study, where some therapists believed that they were making a difference to their patients' life. This is interesting in the light of their feelings of hopelessness, which they also experienced during their work with borderline individuals. However, it might be that therapists needed to believe that they could make a difference to their client's life, no matter how incremental it might have been, in order to be able to manage more effectively the challenges faced in therapy. The following extract gives a sense of the therapist's power, with Leah describing how she had helped her patients rip the benefits from psychotherapy and achieve change. The phrase 'this work saves people's life' sounds very powerful and conveys her desire to contribute to this change in her patients.

*"And the thing, there's something about when these changes happen, they're extremely moving. That's what makes the work rewarding. That's why I also love doing this kind of work. It's not, you know... it's very demanding and difficult but sometimes you also then have moments, which really feel 'Well...I've really made... this process has really made a difference to someone's life'. Quite literally, sometimes I feel that this work saves people's lives. Uhhmm..." (Leah)*

In addition, in both passages below, the therapists felt that the therapeutic work and their role as a therapist in the work were more helpful to their patients than any other types of help might have been. While Agnes compared medicine with psychodynamic therapy, with an emphasis on her patient not being 'ill', Melanie described her feelings about the significant difference between a

behavioural type of modality and psychodynamic therapy, which she provided for her patient. Interestingly, both referred to themselves as the fundamental source of help to their patients, ‘I was probably as much help’ and ‘she must have come to see me’, rather than to the effects of psychotherapy.

*“...I don’t think that she is ill and I think what she needs is psychotherapy and uhm... if she finds it quite difficult to stay in therapy and she is able to stay with me, I suppose...well, I haven’t really thought this through, but I suppose I thought that I was... I was probably as much help as she was capable of receiving, uhm...because she is not ill.” (Agnes)*

*“I think DBT is more behavioural, isn’t it? Managing the...the...which is all very well, but... it didn’t help her...she’s still acting out...7 years she had the therapy and she’d still act out...and then she must have come to see me...and she’s stopped acting out...she’s much calmer now...and people are responding to her differently, you know..” (Melanie)*

Thus, therapists’ experience of having some sort of power to help their patients, who subjected them to very difficult feelings and many challenges, may have been linked with their ability of surviving the patients. In the first instance, Leah described how her ability to survive her patient helped her patient be more mindful and take more responsibility. Thus, her account supports the above - described sub-theme ‘*new experience as template for relating*’. Furthermore, Helen showed an awareness of her need to survive difficult times in her work, to allow her to contain the patient and their relationship to survive.



*“I think she is doing something there to me which uhm...has been done to her. She’s re-creating that situation, and so to be so pushed to the edge that I can tolerate and find somewhere kind of surviving it, and you know, that’s really... and she’ll come back in her much more thoughtful state of mind to the next session, and say and apologise, and thank me for having let her behave in this way and not to retaliate.” (Leah)*

*“The difficult...the really difficult times are purely, for me, about me surviving, in order to have enough...well, first of all actually it’s about me surviving, but then I want to try and get the relationship to survive as well. And, I guess I need to survive first, in order to be able to...uhmm...I think there are times when my trying to contain her is probably secondary to me surviving myself. I think me surviving will contain her in some way.” (Helen)*

In the previous extract, there was a strong sense of internal struggle taking place for Helen, which is also apparent in Melanie’s narrative below. The latter provided an insightful description of how her own struggle with containing her feelings manifested on a bodily level, whereby she ‘stopped breathing’, and, which she felt her clients were able to notice. Yet, she believed that this awareness might have been therapeutic for her patients.

*“I’m just in there with them but when I feel irritated I can feel myself tensing up in my shoulders and I can, you know... I always have to kind of... readjust my position so that I can readjust myself back into the room as it were, if that makes sense. Because I can certainly feel it, I know I stop breathing and I*

*can feel it usually... I'm sure they can feel it, am sure it changes the dynamics, but then I don't think it's always a bad thing for them to know they've an impact as well."* (Melanie)

Therapists' feelings of being in a powerful position to help their patients and their ability to survive the patients unsurprisingly drew on their feelings of self-importance as therapist in the dynamics of the relationship. This notion seems to have manifested itself in alternative ways, as demonstrated by the following illustrations. First, the extract from Maria is a potent display of how important her role as a therapist was, in terms of representing hope for her patient in their relationship. Second, Melanie's account gives a sense of her competitiveness with her colleagues and her unique capacity to care for her patients, which is further emphasised by her saying 'I think it might be me'.

*"...I suppose what I feel is that I might represent that hope...the hope that is important... the hope that human experience is being something bigger and better than their experience of it to date.." (Maria)*

*"... But then, maybe it's not everyone, I think it might be me, although some of my colleagues, they care very much about their clients, and some of them just don't really... They're quite switched off....so, it just depends on the therapist really."* (Melanie)

The passages below further illustrate the therapists' sense of self-importance in psychotherapy and their 'uniqueness' as psychotherapists. For

instance, Leah described how her absence during a break induced her patient's 'pathology', giving the impression that Leah's presence in the patient's life helped her stay psychologically safe. Next, Helen described her own significance for her patient. Her expression 'I was obviously under her skin as well' implies that there was a mutual effect of the patient and the therapist on one another in the intersubjective environment.

*"...She feels, I think, when I am not there, when she, say, has a therapy break, she feels much more...uhmm...well, much less protected from these kind of more...when I'm not there, when she is not seeing me for a period, because of a break...sort of holiday...then I think she is more susceptible to feeling disturbed." (Leah)*

*"Yes, I think she does take me away with her...I think, yeah...yeah...and sometimes mostly that's in a positive way that I'm sure and given that during one of those weeks, there was almost daily email contact, you know, I was obviously under her skin as well in some way." (Helen)*

The final super-ordinate theme within this super-ordinate theme of therapists' omnipotence is their ability to contain their patients. In the context of their work with this patient population, and as other sub-themes have previously indicated it, it appears to be very difficult for therapists to contain their own, as well as their patients' feelings. This is well demonstrated in the following passage, where Helen speaks about her difficulty in containing her feelings, which may not only have been essential but also beneficial for containing her

patient's feelings as well. Her use of humour in her narrative, saying with a laugh that she might have tried to 'deny' her feelings, elucidates this difficulty by implying that it may as well be easier to deny rather than contain them during 'difficult' times.

*"I'm certainly trying to contain my feelings or to deny them... (laughs)...uhmm...I think there are times when my trying to contain hers is probably secondary to me surviving myself. I think me surviving will contain her in some way." (Helen)*

In the following extract, Leah and Agnes both shared the feeling that containment in this type of work was of utmost importance, in order to open up the possibility for the patients' survival of their painful therapeutic process. Both of their accounts suggest that if it had not been for their ability to contain their patients, these unbearable feelings might have destroyed both their patients and the therapeutic relationship. Therefore, containment itself may have been therapeutic for their patients. However, Maria implied that therapist capacity of being containing becomes a skill over the years.

*"Mmm...well, I think if I couldn't take it in, I...I can't help, I mean, I might even harm...depends on what happens with the...just, I guess, push back the feelings...if I don't take it in, if I just push it back, I think...then I'm...well, I'm not being...what I'm doing is not therapeutic." (Leah)*

*“I feel enormous compassion in her struggle & since I’ve been seeing her I have really been holding it together while her life has collapsed... she has really been having it in a way, a breakdown. ...I... my understanding is that if she hadn’t been seeing me once a week, she could have gone off the rail.”*  
(Agnes)

*“I think now...over the years...yes, I would probably.. I’m a bit more confident about being in...and really keeping things at a sort of fairly easy level about being containing...deliberately containing, closing things done and possibly even quite encouraging about what they can hang onto and what is...uhmm...”* (Maria)

In summary, there was a sense of omnipotence in the way in which therapists told their narratives in the above accounts, in order to reflect on their experiences of working with borderline individuals. Furthermore, it appears that their ability to both survive and contain their patients within psychodynamic psychotherapy gave therapists a sense of self- importance and power to help their patients. Thus, it might be that therapists’ feelings of omnipotence were inevitable in their work with this type of patient population.

### 3:2.1.v Labelling is problematic

Last, but not least the issue of labelling vulnerable patients, who have emotional difficulties, with a diagnosis of borderline personality disorder emerged as a strong theme across accounts. The four super-ordinate themes

comprising this master theme are *BPD label is rejected by patients; Label is helpful but unhelpful; Questioning the validity of diagnosis; and Label reinforces patients' psychopathology*. The following extract provides a deep and meaningful description of why patients might have found the diagnosis of BPD painful and why they consequently rejected it.

*“Some find it a very great problem and some patients spend a lot of their time in therapy and out of therapy, fighting the diagnosis... I remember one patient I saw in therapy not long ago, who had initially been given a diagnosis of bipolar disorder, and then his...his psychiatrist he moved to, started to question that diagnosis, and said that he thought it was more BPD. And then the patient disliked the diagnosis and was in constant dispute with his psychiatrist about that diagnosis, and much preferred the bipolar diagnosis. I think there's something about the idea that a problem lies in your personality and it can't be kind of, in a way, located as...so easily as an illness that is separate from your personality.”” (Leah)*

The above extract implies that BPD may have been experienced by patients as an illness, which merged with their personality, and a label, which stayed with them for a lifetime. While Leah described her experience in rather medical terms, Helen's description below depicts a similar, but a somewhat simpler picture of her patient's possible reasons for rejecting her diagnosis. It seems that her desire for being treated equally as a human being, as opposed to someone sick with a label, may have contributed to her difficulty in accepting her diagnosis.

*“That’s really interesting, because one of the issues for my client who has, as I said a lot of medical labels, is about being seen as...seen...what she actually....she obviously wants is the label not to exist.... To treat her as a human being....she wants to be a human being, she doesn’t want to be other labels.”*  
(Helen)

Whilst it seems that patients found the label of BPD to be quite a damaging term, therapists had rather contradictory feelings about it. Whereas most therapists found the diagnosis unhelpful in their work as psychodynamic therapists, some also appeared to have found it helpful. Below, Helen feels that the label is ‘useful in some ways’, yet she expresses uncertainty about what a BPD diagnosis would mean to her patient and how it would affect her life. Interestingly, Helen seemed quite resistant to use the word ‘label’, which could have been due to her negative feelings about labelling someone.

*“I’m not quite sure if you give somebody that label, what it means to them. You know...what...what...what they’d do with that label. I’d rather work with the person on...uhmm... what’s going on for them and the meaning for them....bit I find the label useful in some ways and they might not find it useful... but there’s something for me about giving somebody a label...I mean, you know, there’s limited progress that can be made. I’m not sure how helpful it’d be in some way.”* (Helen)

Similarly, it appears that at times Melanie could find some comfort in the BPD diagnosis, in terms of understanding what she was ‘dealing with’ during her

work with borderline patients. On the other hand, there is a sense of a very powerful feeling on her part that patients could be unfairly put into a ‘box’ and be mistreated by professionals, because of the uncertainties surrounding the treatment of this ‘illness’.

*“At times I think it’s helpful to have a category to put someone in, because it’s useful to know where they’re coming from, in away...to give you a bit more...something to start with. So, I find it helpful, because I can go and look at the books, to get a sense of, you know, not the diagnosis, just top refresh my mind that I’m working with borderlines.. in that sense it’s helpful. In another sense, it’s not helpful because BPD is a place where they place people they don’t know where to place... just to stick them in that category.” (Melanie)*

Furthermore, the process of analysis revealed that some therapists related their experience of working with a label to the DSM criteria. In the following two instances, while both Leah and Maria felt that at times contacting the DSM criteria helped them gain an understanding of the diagnosis of BPD, they were also quick to say that they did not exclusively object to them.

*“I think it’s, you know, they...the DSM are useful descriptive guidelines, they describe a...uhmm...I mean if I look at them and I read them and I think ‘Oh, yeah, that’s a good description of the...uhm...kind of phenomena that we’re dealing with here. But I don’t object to them.” (Leah)*



*“Uhhmm... I think like all diagnostic tools, the DSM is not a tool too unhelpful to visit... Like a theory, it’s not at all unhelpful to visit it...regularly at various points...uhmmm...we live in a very sort of over diagnosed age, don’t we? So, it says quite a lot about it... the need and all that and it’s quite debatable, isn’t it? Half-pathologised (laughs) society...uhmmm... so, holding that in mind, I think I would find it helpful to look at the DSM now and again, but I wouldn’t necessary use it as a literal Bible.” (Maria)*

Another point of interest in Maria’s account above is the way she talked about diagnoses in general. The researcher’s tentative interpretation is that she explicitly constructed her sarcastic way of expressing herself to assert her doubtful feelings about what diagnosing meant to her in today’s society. This was further emphasised by her laugh and the tone of her voice.

A further interesting finding is the relevance of being a psychoanalytic therapist in the context of working with a heavily labelled group. It appears that here psychodynamic therapists mainly understood the meaning of BPD in the context of patients’ difficulty in relating to others, rather than their symptoms based on a set of criteria, as indicated by the DSM-IV. For instance, Agnes and Leah said:

*“They’re constantly wrestling with horrible bad internal objects...and that’s... that’s how I really understand it psychoanalytically. So, in my... in my psychodynamic work, I... I wouldn’t ever think in terms of the DSM criteria, I just leave that to somebody else.” (Agnes)*

*“We’re not particularly interested in giving them a diagnosis as such. I mean we...we talk to them about their experience...almost every day...in every session we’re talking about that but...uhmmm...yeah. (Leah)*

Perhaps, it is no surprise that another super-ordinate theme, which emerged as significant, was the therapists’ tendency to question the validity of the BPD diagnosis. This was emphasised by Maria’s earlier account, above, regarding her doubtful feelings about diagnoses in general, part of which is presented here again, in the following extract, as it seems to capture this theme very well. Following this, Agnes expresses her disagreement with the diagnosis of BPD in connection with the DSM criteria.

*“Uhhmm...we live in a very sort of over diagnosed age, don’t we? So, it says quite a lot about it... the need and all that and it’s quite debatable, isn’t it?” (Maria)*

*“...the DSM criteria don’t have that thing about.. they don’t have a criteria for how you relate to other people, apart from having very intense, up and down, on and off relationships. ...she can’t think about sort of getting to know people and being able to tolerate the things about them that might not be what she’d imagined she wants....so that doesn’t really relate to the DSM and I think it’s a sort of borderline... a general borderline way of relating.” (Agnes)*

Agnes’s account above illustrates how psychodynamic psychotherapists might understand the meaning of the diagnosis of BPD. It appears that her

experience of her patient's maladaptive way of relating to others encapsulates the patient's difficulties in a much more meaningful way than do the symptoms listed in the DSM-IV criteria. Similarly, the next piece of data demonstrates Melanie's doubts about diagnosing people solely based on the set of criteria, while it also offers an insight into why she and her supervisor arrived at a conclusion that her patient may have had borderline personality disorder.

*"I think then it could be for, you know, anybody...teenagers could all become borderlines, if you say impulsive behaviour and all that...uhmm...but I don't think it was based on that list...I think it was based much more...uhmm...on the internal relationship that they've with themselves. I think it was based much more on that...it was a much kind of...deeper...deep examination rather than just looking at the criteria." (Melanie)*

In addition, Leah's narrative below provides evidence for the significance of the context within which therapists work with borderline patients. The phrase 'it is something about the psychoanalytic way of thinking, which basically assumes that we're all patients' shares well how being a psychodynamic psychotherapist might contribute to an understanding of what BPD really is, in the light of the notion that all personalities are characterised by dysfunctional parts which could be integrated better.

*"I suppose I think all people have personality disorders and that's all a matter of degree. I don't think I'm fundamentally different... I... I don't have a diagnosis of BPD, and I don't think I have one, ...but at the same time, I don't*

*think I am fundamentally different, and I suppose, it is something about the psychoanalytic way of thinking, which basically assumes that we're all patients ,.... and that there are ways in which our personalities don't function as well as they could. And I... that I can...that we can be helped to function better...or understand ourselves better...or incorporate aspects of ourselves, you know, learn and change and develop...uhmm..” (Leah)*

Thus, it may not be surprising that a focus on the label during the psychotherapeutic treatment could reinforce patients' 'psychopathology', as the analysis revealed. The following account is a vital display of how Melanie experienced her patients' way of dealing with the knowledge that they had 'something wrong with their personalities', as it were. There seems to be a vicious circle created, as patients could start behaving in accordance with the symptoms of their BPD diagnosis, which then may affect their recovery process. Helen's use of the term 'self-fulfilling prophecy' best encapsulates this interpretation and further implies the notion that labelling can be very damaging, as patients' awareness of having a diagnosis of BPD may become more difficult to cope with than the disorder itself.

*“I think it's been a damaging term...uhmmm...that has been used, because people don't always take the responsibility then, so, I think some of the borderline personality, you can almost say 'Well, oh, well... it's not me... it's not me...'” (Melanie)*

*“I think that was more from my sociological background, my concerns about people being given labels and then only seeing through that label becomes a sort of self-fulfilling prophecy, you know, once you are seen that way, you get treated in that way and it can be a negative spiral, very hard for somebody to get to be put...for people in society, as it were, to get out of it.” (Helen)*

Finally, Agnes provided an emotional account to express her understanding of what having BPD might be like for someone and how knowing it might negatively affect the patient, despite her feeling that at some level it could also be helpful to them.

*“...I just think it sounds really bad and I couldn’t imagine telling a client what I thought... that’s what they had, they might find it quite helpful but I couldn’t imagine telling this client that she had it, because she’d be devastated, I think. ... I couldn’t imagine ever telling her that.” (Agnes)*

In conclusion, it is clear from participants’ accounts that the label of BPD may be a damaging term for patients diagnosed with BPD, contributing to their difficulty in accepting their diagnosis. Furthermore, some therapists found the diagnosis and the DSM criteria helpful at times, which might have been related to their counter-transference feelings of inadequacy and hopelessness. However, most therapists not only felt that being aware of and focusing on the diagnosis was unhelpful, but also questioned how valid the diagnosis might have been when applied to patients who already had emotional difficulties.

### 3:2.1.vi Summary

Overall, while there are a lot of common threads and similarities amid therapists' accounts of their experience with this patient population, there are also individual qualitative differences in their feelings, beliefs, thoughts, attitudes and reactions towards working with borderline personality disorder in psychoanalytic psychotherapy. It seems that Leah valued the positive effects of the psychodynamic model on her work to the greatest extent, which, she believed, most patients usually benefited from. While Agnes also found the modality important, she mainly appeared to indulge in her role as a psychodynamic therapist, carrying the strongest sense of self-importance in her work. Although, all therapists described negative counter-transference feelings in their work, Helen and Maria's feelings seemed to evoke the most challenging experiences. In Maria's case, these feelings were such that they were re-enacted in the process of the interview, whereby her cognitive abilities got affected to such extent that she struggled with her ability to reflect on her experience.

Next, it appeared that the main focus of Helen's work was her own survival in the room, which, in turn, was also necessary for containing her patient. It is felt that Melanie displayed the strongest feelings against labelling, which may have unduly contributed to the researcher's experience of her as being a very protective therapist. Finally, all the five master themes presented and described above interplay with one another. It seems that negative counter-transference feelings most characterised therapists' work with BPD in psychodynamic psychotherapy, drawing on certain difficulties and obstacles

within therapy. Thus, empathy, the therapeutic relationship and modification of the psychodynamic model were significant factors, which facilitated the therapists' ability to deal with these difficulties. These abilities involved containment, the survival of the patient and the relationship, and an understanding of the stigmatising effect of BPD as a label.<sup>17</sup>

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<sup>17</sup> The relationship between all these themes is more thoroughly discussed in the 'Discussion' in section 4.1 on page 105.

## Chapter Four: Discussion based on findings and Conclusions

Participants drew on a variety of understandings in order to make sense of their experiences, from which five master themes emerged: negative counter-transference feelings; “sitting in the dark together”; hindrance in the therapeutic work; therapist omnipotence; and labelling as problematic. As many of their super-ordinate themes are inter-related, most of them are discussed in relation to another rather than in a step-wise fashion. Table 3 is not a model or theory, but a representation of the significant themes, which are discussed in this chapter. Reference to the data is given where it is appropriate. Direct quotes from the therapists’ own words are integrated into the text and given in italics, so that the reader can differentiate them more easily from the rest of the text. There was reference to one or two therapists’ quotes only, in relation to discussing each theme. Due to constraints in word length, the researcher placed more focus on those themes presented within the analysis, which appeared to be more significant in association with the earlier described research literature. The *Discussion* chapter is divided into five sections and the *Concluding remarks* chapter is divided into six sections.

**Table 3: A representation of the themes discussed in this chapter**

	Negative Counter-transference	“Sitting in the dark”	Hindrance in therapeutic work	Therapist omnipotence	Labelling as problematic
Sub-theme 1	Hopelessness	Bond between therapist & patient	Significance of modifying the PD model	Power of therapist	BPD label is rejected by patients
Sub-theme 2	Inadequacy	Significance of ‘Being’ rather than ‘Doing’	Difficulty in accessing empathy	Ability to survive the patient	Label is helpful but unhelpful
Sub-theme 3	Difficulty in containing feelings	New experience as template for relating	Interpretations as unbearable	Self-importance as therapist	Questioning the validity of diagnosis
Sub-theme 4	Therapist cognitive abilities affected	Empathy as crucial	Therapeutic relationship is threatening	Capacity to contain the patient	Label reinforces psychopathology



## 4:1 Discussion

### 4:1.1 The effects of negative countertransference feelings versus therapists' 'omnipotent' feelings

The therapists in this study described having negative countertransference feelings as very frequent experiences in their work with borderline individuals. These feelings have also been recognised in the literature as quite common amongst psychodynamic psychotherapists working with this patient group (Schwartz, 1999). While sometimes it was difficult for the therapists to understand and work with these negative countertransference feelings (Grohol, 2007), they also found that an awareness of these feelings was not only crucial, but also effective in enhancing their understanding of their patients' difficulties (Kernberg, 1975). Most therapists reported to have experienced negative countertransference feelings of hopelessness and inadequacy (Schwartz and McIntyre, 1998), as a result of their fear that their patients might not be helped by psychotherapy.

According to Winston (2000), borderline patients' challenging behaviour and feelings of uncertainty about the treatment can promote therapeutic nihilism in therapists. This was supported by the account from Maria, who referred to her hopelessness as *'quite a kind of nihilistic sort of despair'*, which left her wondering whether her patient's condition would ever improve. The feelings of hopelessness may have contributed to the therapists' feelings of inadequacy. For instance, Agnes felt inadequate and *'powerless'*, which she believed was *'something borderline people do to you... to make you feel completely useless'*.

Agnes's feelings resonate with Goin's (1997) view that therapists can sometimes blame borderline patients for their distress by saying 'they do this to us'. However, Lemma (2003) argues that during countertransference the therapist may respond to the client by experiencing similar, or the same feelings towards them, as the ones which the client transferred onto them from past relationships. Furthermore, borderline individuals' feelings of being hopeless (Schwartz and McIntyre, 1998) and powerless to keep their illness from destroying their relationships (Heller, 1991), may have affected the therapists' feelings in the treatment process. For this reason, Schwartz (1999) argues that therapists must be aware of their own strong emotional responses as well as their countertransference reactions to their patients.

The findings that the therapists' feelings of hopelessness and inadequacy were their countertransference reactions towards borderline patients are concordant with those of another qualitative study, conducted by Commons Treloar (2009), where clinicians felt frustrated and inadequate to face the challenges of working with borderline patients. Furthermore, the findings here also support those reported by Gallop and Wynn (1987), in which mental health professionals' feelings towards borderline patients were characterised by a lack of control and incompetence. Interestingly, and in contrast to the therapists' negative countertransference experiences in this study, where some therapists felt '*powerless*' and '*completely useless*', their '*omnipotent*' feelings of power and self-importance also emerged as significant themes.

For instance, despite their feelings of hopelessness, most therapists expressed some beliefs that their presence in their patients' lives, both in and out of psychotherapy, involved some sort of 'power'<sup>18</sup>, which not only enhanced patients' capacity to improve (and even to heal) in the therapeutic process, but also protected them from traumatic experiences outside psychotherapy. Thus, a few therapists maintained that some of their borderline patients benefited, and may even recovered, from the effects of psychotherapy, which is in line with some previous research findings (e.g. Stevenson and Meares, 1992/1999). Leah experienced the change in her patients as *'extremely moving, which makes the work rewarding'* and went as far as to say that *'this work saves people's lives'*, implying that she had 'powerful' abilities to cure her patients. Research has shown that because borderline clients are vulnerable to the effects of iatrogenic deterioration in psychotherapy (Fonagy and Bateman, 2006a) they are intolerant of therapeutic errors (Shearin and Linehan, 1993). Therefore, therapist skill is a crucial element for working with these patients and for promoting improvement. It may thus be possible that in the context of the therapists' experiences of negative countertransference feelings, their 'omnipotent' feelings of 'power' were necessary for enhancing both their therapeutic skills and confidence to work with this patient population.

Similarly, the therapists' 'omnipotent' feelings of self-importance are also interesting findings in terms of their negative countertransference feelings of inadequacy. For example, Helen reflected on her feelings of being an inadequate therapist by saying that *'often that's been thrown at me that I've been*

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<sup>18</sup> The therapists did not use the word 'power' in their accounts. This is the researcher's own choice of words in an attempt to make sense of their experiences.

*unprofessional, useless and I've done this and that wrong*'. Later, when she tried to make sense of her inability to leave her patient in the room, due to her negative countertransference experience, she felt that her patient also took Helen away with her in a positive way, because Helen *'was obviously under her skin as well in some way'*. The theme of self-importance was emphasised well in the account from Melanie, in which she felt that caring for borderline patients *'just depends on the therapist really'*, and in which she expressed her feelings of 'uniqueness' by saying that *'I think it might be me'*. It might be possible that Melanie's patient wanted to see her as someone unique, which then evoked 'omnipotent' feelings in her that she was. Similarly, Malcolm (2004) suggests that because the patient in therapy needs the omnipotent parent of early childhood they might see the therapist as someone with special power, special intelligence and wisdom. When there is idealisation in the transference, it might evoke grandiosity in the therapist. Thus, through the process of transference, the patient plays part in the omnipotence, which the child attributes to the parents, hence to the therapist.

Alternatively, it is possible that these 'omnipotent' feelings emerged as a reaction or defence to the therapists' experience of negative countertransference feelings. Thus, 'omnipotent' feelings may have been the therapists' positive countertransference reactions to their patients in the transference. There has not been one single study found, either nomothetical or ideographical, which supports this interpretation or provides evidence for similar 'omnipotent' feelings of therapists' experiences.

At times negative countertransference feelings had such major impacts on the therapists' cognitive abilities that they were unable to either think clearly during the sessions or remember details of them afterwards. Maria described that her patient's '*mind was blank*', which also had an effect on her mind as well. She said '*I found it really hard to literally have images in my own mind*' in the patient's presence. There is evidence that most patients diagnosed with BPD have suffered some sort of abuse in the early stages of their lives (Perry and Herman, 1993), which led to their cognitive immaturity and inability to make sense of adverse life experiences (van der Kolk *et al*, 1994). It could be that if the patients' cognitive ability to describe their diverse life experiences was affected, their difficulty in thinking and expressing themselves clearly in therapy also affected the therapists' cognitive abilities both inside and outside psychotherapy.

Little (1951) maintains that therapists' capacity to work with countertransference is crucial, as most of the therapeutic work with borderline clients can be done through countertransference and the therapist's identification with the patient's id. It might thus also be possible that, due to the intensity of negative countertransference feelings, the therapists identified with their patients, which helped them to understand (and even to experience) the patient's difficulty in thinking and expressing themselves clearly. Consequently, experiencing these difficulties may have led to their feelings of hopelessness and inadequacy. This phenomenon was also manifested during the interview process with one therapist, where the researcher experienced Maria as someone who had difficulties in staying focused and using language effectively, while she was

trying to describe her negative countertransference experiences and their effects on her cognitive skills in and out of psychotherapy.

The abilities to remember, fantasise, make judgments and come to conclusions are few examples of mental or cognitive processes (Smith *et al.*, 2009). Because this cognition is multi-dimensional, dynamic, affective, embodied and it is closely related to the individual's engagement with the world, it takes place within an informal context of reflective activity. Therefore, cognition and language are important aspects in IPA research, which also seemed significant for this phenomenological study, as cognitions are not isolated separate functions but a part of being-in –the-world (Smith *et al.*, 2009). Any phenomenon that occurs in an individual's life has existential significance and draws on a great amount of mental activity.

Thus, IPA is interested in experiences in which the participant is able to think clearly and tries to make sense of what is happening. The researcher can get an understanding of participants' cognition through their stories, language and thus, meaning making. Interestingly, the researcher in this study also found that it was difficult to think clearly and to engage fully with Maria during the first interview. According to Smith *et al.* (2009), the IPA researcher engages in double hermeneutics, in which the researcher is trying to make sense of the participant trying to make sense of their own experience. Thus, the researcher's experience of Maria in the interview might be understood as phenomenological in the sense that the experience between the researcher and the therapist paralleled the experience between the therapist and her patient. Therefore, this

process helped the researcher make sense of the participant trying to make sense of her negative countertransference experiences. That is, the therapist's inability to think clearly and to describe her experience through language affected the researcher's ability to think clearly and to describe this phenomenon during the interview process.

One way of describing the therapists' difficulty in thinking clearly about their patients was their tendency to use metaphors, which helped them share their experiences. For instance, Leah found the metaphor '*scramble my mind*' helpful to describe her experiences of her negative countertransference and their effects on her cognitive ability in her work. Heidegger (1927) contends that the interpretations of a certain phenomenon are influenced, limited and enabled by language and the use of metaphors. Most therapists in this research resorted to using metaphors to describe and make sense of their experiences throughout the interview. Shinebourne and Smith (2009) argue that metaphors can help an individual understand another individual's experience and its meaning. Furthermore, Lyddon *et al.* (2001) suggest that using metaphors in psychotherapy provides the client with helpful tools to express those emotions, which might have been unexplored or unrecognised before. Similarly, the metaphor, which Leah used in the interview, also helped her symbolise her unusual experiences of her patient in the context of psychotherapy, where her mind was 'scrambled' like an egg, resulting in her fear that her mind was going to stop functioning.

#### 4.1.2 The significance of empathy and containment for patients who suffer from BPD

Participants in this study found that empathy was crucial in their work with this vulnerable client group. Hannig (1995) writes that deep empathic understanding, accurate interpretations, and reflections may not only help the release of the borderline individuals' intense pain, but also provide support and reassurance to the patient. Leah thought that therapists had to experience different kind of feelings towards their patients and reflected on her own experience as *'I don't connect empathy so much with positive feelings necessarily'*. Merleau-Ponty (1962) maintains that whilst one can observe and experience empathy for another person, it is not quite possible to share entirely the other's experience, because their experience belongs to their own embodied position in the world.

The findings in this study revealed a challenging view to that of Merleau-Ponty. This is because, interestingly, most participants explained their experience of empathy in relation to projective identification (Leah's own words), in which the therapist identified with the patient's projection of their feelings, attitudes and behaviour (Klein, 1946), as if they were experiencing those themselves. Leah found that through this process *'in a way, you're talking about your own experience, if you've empathised in this deep way'*. Similarly, Agnes recounted her experience of identifying with her patient's projections as *'I am not just empathising with her, I am experiencing her'*. According to Eagle and Wolitsky (1997), therapists' recognition and experience of countertransference



feelings and projective identifications can be used for empathic purposes, as those feelings and experiences can serve as tools to understand the patient and to make bonds with them.

Most therapists shared this view here in this study, as through the process of projective identification the therapists seemed to be more able to understand what their patients were feeling and what they were going through, which, in turn, facilitated a deeper connection between them. Kernberg (1975) argues that when the clinician's own early experiences are reactivated alongside the mechanism of projective identification, anxiety might be directed towards the patient with a loss of ego boundaries. As a result, the therapist's narcissistic withdrawal from the patient can contribute to a loss of empathy and to the danger of disruption of the analytic work with that borderline patient (Kernberg, 1975). This might provide an understanding of the findings that at times the therapists had difficulty in accessing empathy towards their patients.

However, the therapists in this study related this difficulty to their negative countertransference feelings. For instance, Agnes thought that *'the loss of empathy is the counter-transference reaction'* while Maria felt that *'empathy is much more difficult when there are negative counter-transference feelings'*. Despite this difficulty, all therapists maintained that empathy was a very important factor in their psychodynamic work with this patient population. While in some cases a lack of empathy contributed to a broken connection between the therapist and the borderline individual (Posner *et al.*, 2002), most accounts here suggest that surviving this difficult phase was therapeutic rather than disruptive

in the analytic work (Kernberg, 1975). As Helen said *'you have to just hold your breath and hang on in there..., and something on the edge softens and you can begin to work again'*.

Based on the accounts given in this study, an understanding is that working through the therapists' difficulty in lacking empathy for their patients may have resulted in a stronger bond between therapist and patient. This is because the therapists' ability to contain their negative countertransference feelings, and their patients' projections, may have facilitated the survival of their relationship. Furthermore, the therapists' high empathy, and ability to understand their borderline patients, may have also decreased their negative countertransference experiences in their work (Peabody and Gelso, 1982), and thus strengthened the connection between them.

While empathy seems vital for working with borderline patients in psychodynamic psychotherapy, containment was another crucial factor found for this patient group. That is because the therapist's capacity to contain negative countertransference feelings may lead to significant changes in the patient (Carpy, 1989). However, this study revealed that the therapists found it difficult and at times almost unable to contain their negative countertransference feelings, which they experienced as being concerning in their work with borderline patients. This difficulty became apparent in the way the therapists reflected on their experiences in the interviews, since most therapists took comfort in using a range of strong metaphors<sup>19</sup>, a tendency which was also described earlier and

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<sup>19</sup> See a description of the significance of metaphors used in language in section 4:1.1 on page 109.

which was consistent throughout the interviews, while describing and trying to make sense of their experiences.

For instance, Helen reflected on her difficulty in containing her feelings as *'I am receiving gunshots, but I am also rendered sort of speechless'*, while Leah felt that her patient subjected her to *'such tirades, such horrible experiences'* that she struggled with managing her feelings. The therapists' complex accounts in relation to this theme suggest that there may possibly be something about the work with borderline patients, which is indeed challenging to manage effectively in the context of psychotherapy. For instance, Helen described her ability to cope with her negative feelings as *'part of me steps out, probably out of the room... and it's slightly like holding my breath for the entire session'*. This resonates with Hinshelwood's (1999) account that mental health professionals can 'emotionally retreat' from patients with personality disorders, as they bring up difficult feelings in them and challenge their beliefs about their professional identity. As opposed to the therapists' difficulty in containing negative countertransference feelings, their capacity for containing their patients in the process of psychotherapy also emerged as an 'omnipotent' feeling.

#### 4:1.3 The significance of the relationship in the face of obstacles during the therapeutic work

The therapists' ability to survive their patients and their negative counter-transference feelings in the relationship, when the patients' behaviour was

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destructive, was another ‘omnipotent’ feeling suggested by the findings. The therapists in this study felt that their patients’ experiences of them, as having the capacity to survive the patients, helped their patients to relate to others, and consequently to themselves, in a more functional way. Helen experienced the significance of her survival as *‘I think me surviving will contain her (patient) in some way’*, while Leah described how her surviving the difficult times would help her patient to *‘come back in her much more thoughtful state of mind’*. Winnicott (1968) suggested that the psychodynamic therapist’s capacity to survive the patient’s attacks and hate is a central element in helping the individual to make use of the therapist as someone who is outside the patient’s control. According to Kernberg (1975), working with borderline patients has often been understood in terms of an early intensive emotional reaction, which is related to both the patient’s premature, intense and chaotic transference, and the clinician’s ability to withstand psychological stress and anxiety.

Some therapists also expressed the importance of *‘the relationship to survive as well’* (Helen). Hence, the therapists’ survival of the patient and the relationship’s survival of difficult times may have provided patients with a new experience in psychotherapy; relating to another human being in a deep and meaningful way (Westen, 1990). Therefore, through the awareness of, and the ability to, manage and contain their countertransference experiences, the therapists might have provided the patients with the necessary experience for being understood and accepted (Goin, 1998). The findings in this study suggest that the connection between therapist and patient was also imperative for providing the patient with this new experience to facilitate change in therapy.

Thus, the significance of the bond between therapist and patient was raised as a vital factor in the therapists' work with borderline patients; particularly in their ability to contain their negative countertransference feelings, and their patients, and in their capacity to survive their patients.

Participants referred to this bond as '*deep connection*', '*good relationship*', '*strong working alliance*' and '*attachment that is not abusive*'. In their experiences this bond was therapeutic itself for the borderline individual as it helped them function better in the outside world, improved their ability to function at work, and built and maintained their friendships, and intimate relationships (Stone, 2006). This is in line with previous research evidence (e.g. Paris, 2005; Winston, 2000), which showed that the therapeutic relationship, or a bond between therapist and patient, is one of the main hallmarks to facilitate change when working with people with personality disorder in psychotherapy. Maria described the therapeutic relationship as something that is '*enabling them [borderline patients] to realise that there are relationships....to be that in the world, as opposed to a sort of fractured, isolated kind of understanding of that*'.

The literature suggests that borderline individuals tend to experience others as malevolent, experience relationships in need-gratifying ways and be highly sensitive to abandonment (Westen, 1990). Thus, it might be that having a different relationship, in which the patient experienced the therapist as empathic, and learnt to relate to the therapist in a new and healthy way, was helpful for the patients. As Melanie put it, '*just having another experience itself is helpful... a better experience*'. This view speaks to the findings by Paris (2005) that the

therapeutic relationship with the therapist helps the borderline individual to break maladaptive relationship patterns and improve their relationships with others. According to the therapists' accounts, this better experience also involved the patient learning that the therapist '*can make mistakes*' (Helen) and '*does not get things right all the time*' and accepting that the therapist is '*not perfect*' (Leah). Thus, learning and accepting that others might be different from the patients' expectations in a relationship may have challenged their existing maladaptive patterns and provided them with a new, and a better, experience of how 'to be' in a relationship (Stolorow, *et al.*, 1987).

It is believed that psychodynamic psychotherapists' empathy, non-possessive warmth, and genuineness are significant for 'being with' the patient, in order to establish a good working alliance (Mitchell *et al.*, 1977). Here therapists experienced that 'being with' the patient in therapy was more significant than 'doing to' something to the patient in the therapeutic work. There seemed to be a connection between having a good therapeutic bond between the patient and the therapist and the therapist's ability to emphasise (and arguably to contain) the patient. Helen expressed the significance of empathy for the relationship by saying '*I don't really try to change anything... I just try to be with*', while Melanie's description of '*somebody being able to sit with you in the dark, rather than trying to push you out of the dark*' powerfully signifies the importance of staying with and containing the patient's real pain. The latter resonates with the writing of Phillip W. Long, where he points out that the therapeutic relationship must be established within the patient's real experiences

with the therapist, in order to accept certain behaviours of the borderline patient (Grohol, 2007).

#### 4.1.4 Is the psychodynamic model effective for working with borderline individuals?

In the therapists' accounts, the relationship between them and their patients was threatening to borderline clients, despite their need for a deep connection with others. Melanie described how the borderline individual is *'wanting the intimacy but also finding it too much'*, while Agnes felt that *'just having that connection feels intolerable'*. This paradox seems to be characteristic of people with BPD, who have difficulty in establishing and maintaining close relationships, yet also have the need for a safe and trusting bond with the therapist and significant others (Goin, 1988). Patients' fear of relationship with the therapist might be better understood by Fonagy and Bateman's (2006a) theory, which suggests that when psychodynamic therapy activates patients' attachment system, behavioural and psychological disturbance may occur. Similarly, the therapists in this study found that the idea of attachment was threatening to their patients because of *'their fear and phobia of abandonment'* (Melanie). This seems in line with the view that patients with BPD are afraid of a close relationship because of their vulnerability, fear of losing the other and difficulty in having stable and well-balanced relationships (Gunderson, 1997).

On the other hand, as Fonagy and Bateman (2006a) suggest, the activation of the attachment system is essential for the borderline individual if they were to

develop psychologically within interpersonal relationships. Thus, it is proposed that a secure environment and attachment provided by the therapist could facilitate better work on changing maladaptive working models in BPD (Dozier and Tyrell, 1998). Fonagy and Bateman (2006a) maintain that patients' 'reduced mentalisation' can contribute to the difficulty in maintaining the therapeutic relationship with a therapist for those borderline patients whose problem is mainly one of attachment<sup>20</sup>. Thus, it might be that the therapists in this study found the therapeutic relationship more challenging with those patients, who had greater attachment problems. Furthermore, it is possible that patients' 'reduced mentalisation' affected their ability to understand interpretations given by the therapists. This assumption speaks to the findings here, which revealed that borderline individuals found the psychodynamic model and mainly interpretations unbearable.

All the therapists felt that this was one of a few hindrances in their work with their borderline clients within the psychodynamic modality. This finding is also consistent with the view that the traditional psychodynamic model can be a high-risk intervention with more severely personality-disordered patients because of their difficulty in understanding transference interpretations (Gabbard *et al.*, 1988). Whilst Agnes felt that patients *'find interpretations persecutory'*, Maria pointed out that *'interpretations can be quite attacking'* and the patients *'probably tend to be better off'* without them. Another view is that when therapists give erroneous interpretations patients may feel that these are intentional and suddenly withdraw from the relationship, due to feeling hurt, angry, lonely and unfulfilled (Hannig, 1995).

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<sup>20</sup> See a discussion of the meaning of 'reduced mentalisation' in section 1:2.2.ii on page 20.



Bond *et al.* (1998) suggest that interpretations can result in deterioration of alliance when the alliance is weak, but can enhance it when the alliance is strong. While all the therapists emphasised their patients' difficulty in forming an alliance and handling interpretations, therapists did not talk about the effect of interpretations on the working alliance. It might also be possible that those borderline patients who had higher levels of ego strength, and the ability to establish good working alliance, found interpretations, especially transference interpretations, useful (Bond *et al.*, 1998). This may provide an understanding for the contrast in some therapists' account, which indicated that while at times the patients struggled with understanding the therapists' transference interpretations they also found them very helpful. Helen described that giving interpretations to her patient was *'sometimes so helpful to her...because I probably gave it to her not when she's the most angry'*. This implies that the timing of the transference interpretations, rather than the avoidance of giving interpretations, might be more significant for borderline patients in psychodynamic psychotherapy.

Similarly, Hannig (1995) maintains that the timing of transference interpretations must consider the borderline client's terror and fragility during the release of their pain. This is because the feeling of therapist neglect, rejection, or insensitivity may lead to negative transference, involving accusations, ambivalence and attack, and therapists' negative transference. The account from Maria supports this view where she suggested that her patients might have found interpretations shameful and exposing, and thus she liked *'to do it when we moved away from that moment...especially with this sort of patient group'*. Hence, it could be that the timing of giving interpretations may have also contributed to the strength of the

working alliance in working with borderline patients, because of their experience of the therapist as trustworthy and understanding (Gabbard *et al.*, 1988). The significance of considering the timing of interpretations implicitly called for the need to modify the psychodynamic model therapists worked in. Such modification in this study involved implementing cognitive (Linehan, 1993) and supportive elements (e.g. Rockland, 1989; Clarkin *et al.*, 2007) into the therapists' work.

The significance of modifying the psychodynamic model for working with borderline patients has been supported with some of the existing findings in the literature. For instance, the mentalisation-based treatment (MBT; Bateman and Fonagy, 2004b) and transference-based psychotherapy (TFP; Kernberg *et al.*, 2002) are modified versions of the psychodynamic therapy. Randomized controlled trials found evidence for the usefulness of cognitive-approach techniques in MBT (Bateman and Fonagy, 1999). Similarly, most therapists here felt that incorporating cognitive-therapy techniques into their work was more useful than staying strictly within the framework of the psychodynamic approach. Maria reflected on the importance of '*putting in something quite cognitive to encourage the positive transference*'. It might be that the use of cognitive elements also facilitated a bond between therapist and their patients.

This bond was further reinforced by the therapists' ability to provide support for their clients. For instance, Melanie emphasised the significance of being supportive in her work and argued that it is not only '*the supportive element but also seeing the whole of you*' which makes a difference with borderline patients. This is consistent with the view of Waldinger and Gunderson (1984), which argues

that a focus on recent experiences, where the therapist adapts a more active role, is more beneficial to borderline patients than psychoanalytic psychotherapy is in its traditional form. Although some cognitive factors and the element of being '*quite concrete*' (Agnes) with borderline patients also emerged useful here, the therapists experienced that working solely on a cognitive level was not enough with this patient population. Moreover, a focus on patients' faulty cognitions might have neglected their difficulty in having interpersonal relationships, showing emotions and emotional attachments to significant others in their lives (Grohol, 2007). Therefore, a bond between therapist and client, and mainly the 'being with' factor, that is staying with the client's pain, was more significant for the therapists' ability to work with borderline individuals than the 'doing to' factor, that is treating their symptoms alone.

#### 4:1.5 Can treating the diagnosis of BPD as a label become problematic within the context of psychotherapy?

The therapists' accounts in this research pointed to some evidence that patients diagnosed with BPD tend to reject their diagnosis. Leah found that her patients '*spend a lot of their time in therapy and out of therapy fighting the diagnosis*' while Helen experienced that her client '*obviously wants the label not to exist*' and to be '*treated like a human being*'. Dvoskin (2002) argues that the label attached to this condition causes a lot of emotional pain to patients and leads to sub-standard treatment of people diagnosed with BPD. Similarly, Nehls (1998) argues that mental health professionals tend to see patients with BPD as 'manipulative', 'difficult' and 'demanding'. Although these authors suggest that

mental health professionals' attitude can contribute to and negatively effect patient's behaviour in therapy, and the way they relate to their illness, this study found no evidence for these claims. In fact, here the therapists had a caring and empathic attitude towards their patients.

Thus, the patients' rejection of their diagnosis in this study might have been a result of their loss of a sense of 'normality', because their diagnosis cannot be located as an *'illness that is separate from their personality'* (Leah). Sartre (1956) maintains that the two ways of being; being-for-itself (consciousness) and being-in-itself (thingness) are not only opposed to one another but they are also interrelated. This is because the gaze of another person can objectify us; we turn into a thing for another consciousness and discover our body as an in-itself, which is still us. According to Sartre, this experience is accompanied by feelings of shame, humiliation and even nausea, because to become oneself, as a result of another's gaze, is a vitally alienating experience; the self is separated from its true essence (freedom or consciousness) in becoming an in-itself (a thing). For only another can objectify us, paradoxically, we are alienated by being *'something'* and not nothing. This in-itself of the body is regarded to be a disease in phenomenology.

However, Svenaeus (2009) contends that the gaze of another need not be alienating, in terms of making us feel ashamed and disgusted, but could make us feel safe and secure because of, rather than in spite of, our body. Thus, it depends on who gazes upon us, and on the relationship between the one who looks upon us and us who are being looked upon by another. The implications of this in

psychotherapy may be that when psychotherapists look upon patients through the label of BPD, it might alienate patients because of their feelings of shame and humiliation. However, when a therapist has no pre-judgmental views and looks upon a patient as a human being then the patient with BPD might feel safe and secure. This view supports the findings that empathy and just “sitting in the dark” with patients were therapeutic for the borderline patients in psychodynamic psychotherapy.

In this study most therapists’ understanding of BPD supports the view of psychoanalytic thinkers (Zanarini *et al.*, 1990; Paris, 2005); that patients’ maladaptive ways of relating to themselves and significant others, and their difficulty in maintaining deep and meaningful relationships, are the major indicators of BPD. Thus, the therapists distinguished between their psychodynamic conceptualisation of what BPD meant for them as an ‘illness’ and its description in the DSM-IV criteria. For instance, Agnes held the view that she ‘*wouldn’t ever think in terms of the DSM criteria*’ because ‘*they don’t have a criteria for how you relate to other people*’. Thus, most therapists questioned the validity of the diagnosis of BPD as it is described in the DSM-IV. Agnes’s view is interesting seeing that the term ‘borderline’ emerged from the psychoanalytic way of thinking (NAMI, 2006), which later contributed to the formulation of the diagnosis in the DSM criteria (Beck *et al.*, 2004). As Binks and his colleagues (2009) previously noted, perhaps the vital problem is in the polythetic definition of BPD, as people who fit the same set of criteria of this diagnosis may have very different personalities.

The findings here support some psychodynamic authors' view that the inability of an individual to relate to another contributes to the development of 'psychopathology'. For instance, Mitchell (1988b) argues that 'pathology' stems from constricted patterns of relatedness and not from missing infantile experiences residing in the patient. As the self is constantly developing (Sartre, 1956), and as the therapists in this study experienced, patients in psychotherapy may learn better ways of relating to the therapist as well as to others. Some studies suggest that the majority of borderline patients can even make a recovery in long-term psychotherapy (e.g. Paris and Zweig-Frank, 2001; Stevenson and Meares, 1992). Therefore, this raises some existential (and ethical) issues about the nature of diagnosis, as a person might be freed from the disorder through the therapeutic treatment, but not from the label. In this study it appeared that the label of BPD was a damaging term for patients diagnosed with the disorder, which might have caused their difficulty in accepting their diagnosis.

The therapists here empathised with their patients for having negative feelings towards their diagnosis, as most therapists believed that borderline patients' awareness of the label (and its stigmatising effects) could reinforce and enhance their already existing difficulties. Helen referred to this as '*self-fulfilling prophecy*' because '*once you are seen that way, you get treated in that way and it can be a negative spiral, very hard for somebody to get to be put... for people in society, as it were, to get out of it.*' Thus, self-fulfilling prophecy is when our negative expectations of another person may prompt us to behave in a way that evokes the other to act in accordance with our false perceptions (e.g. Miller, 1986; Word *et al.*, 1974).

While the therapists found that the label was mostly unhelpful in psychotherapy, at times they also found it helpful. Firstly, they found the label unhelpful because they were aware of how it can draw on their pre-judgmental beliefs and attitudes towards the borderline patients and consequently '*there's limited progress that can be made*' (Helen). Although, most therapists felt that '*the DSM are useful descriptive guidelines*' (Leah) and '*not a tool unhelpful to visit*' (Maria), they mainly emphasised the importance of focusing on the patient's emotional experience, and the relationship between therapist and patient, rather than on their diagnosis. Social psychological research (e.g. Dovidio *et al.*, 2000) found evidence that prejudice could arise in certain contexts, which involve ambiguous choices. Therefore, some decisions made within these contexts may prevent challenging those decisions as being discriminatory. Aviram *et al.* (2006) argue that psychotherapy is a similar context, marked by ambiguity and multiple perspectives, where stigma can easily influence therapists' choices and decisions without their awareness.

Here the therapists appeared to be aware of the consequences of labelling patients in psychotherapy and the possibility that a focus on the label of BPD may also cause therapists to overlook patient's symptoms, as well as their real strength, and to dismiss or minimise patient's difficulties (Aviram *et al.*, 2004). Racker (1957) suggest that certain emotional responses may stem from an unconscious identification between therapist and patient, leading to a 'needed' or 'repeated' early relationship. In order to prevent this from happening, an awareness of these countertransference feelings is important, so that the therapist does not justify them with the stigma of the disorder. In this study, the therapists

seemed to be aware of their countertransference feelings and found supervision as necessary for working with borderline patients. For instance, Maria found that *'the best thing for me working with borderline people is always to get help from my supervisor or peer group'*.<sup>21</sup>

Secondly, even though the therapists were aware that labelling and the diagnosis of BPD might have negative effects in psychotherapy, there were times when they also found the label as being helpful. Melanie thought that her awareness of the diagnosis enhanced her understanding of her patients and their problems, because *'it's useful to know where they coming from, in a way, to give you something to start with'*. It might be that an awareness of the nature of the diagnosis and its consequences may have reduced the therapists' anxiety and increased their self-confidence and competitiveness as psychotherapists working with borderline patients.

Furthermore, according to Melanie, people might be unfairly diagnosed with BPD, because it is *'a place where they place people they don't know where to place... just to stick them in that category'*. Thus, it seems that borderline personality disorder is a disorder, both historically and currently, which draws on many misunderstandings. According to Hoffman (2007), the nine symptoms attributed to this condition can present in 200 different ways, which is even further complicated by the possible comorbidity of other disorders with BPD. This tends to cause some confusion, amongst health professionals and lay people, and to contribute to a phenomenon that maybe termed "surplus stigma"

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<sup>21</sup> Supervision was another important super-ordinate theme that emerged in this study but was not included in the findings due to the word constraint.



in BPD. However, hope has been restored by recent research evidence which demonstrated the effectiveness of a range of different treatment approaches, such as the Dialectical Behaviour Therapy (DBT) by Linehan (1993), psychodynamic psychotherapy (e.g. Leichsenring and Leibing, 2003) and modified versions of psychodynamic psychotherapies (Fonagy and Bateman, 2005; Kernberg *et al.*, 2002).

## 4:2 Concluding remarks

### 4.2.1 Evaluation of the research study

The current study has attempted to provide a rich and comprehensive account of psychodynamic psychotherapists' experiences of working with people with BPD. Given that there has only been one other qualitative study (Commons Treloar, 2009) found by the researcher, which investigated different mental health professionals' experience of working with BPD, and that previous studies relied on quantitative methods of enquiry, comparisons of current findings with previous findings of similar research have been limited. However, there was an attempt to describe each emerging theme with associated existing publications on BPD in the research literature and to compare the results with previous research findings where it was possible. This study has been evaluated in two ways.

First, Yardley's (2000) four principles were selected for evaluating the quality of this study. Sensitivity to context was demonstrated by focusing on the idiographic and the particular in each participant's account. The researcher tried to be empathic with the participants during the interviews, while the participants' needs and any possible difficulties were considered. For instance, the researcher struggled with thinking and expressing herself clearly in the first interview with Maria, where a parallel process between the therapist's work and the interview was experienced. There was sensitivity to the data with which the researcher engaged throughout the analysis, and to the research literature, with which the findings were associated in the discussion. Commitment and rigour were shown

by the researcher's attempt to be thorough in the study (e.g. homogeneity of the sample) and by ensuring quality and consistency through the interviews, and the detailed analysis of the data. The attempt to explain the stages of the research process in a clear and consistent way to the reader hoped to achieve good transparency, while writing up the findings in a careful and comprehensive way hoped to demonstrate coherence. Finally, this study has attempted to have an impact by conveying something interesting, important and useful to the readers.

Second, Willig (2001) contends that the evaluation criteria must be in accordance with the epistemological underpinnings of the study. This study located itself within a contextual constructionist position with a focus on meaning in context, hermeneutic interpretation and the acknowledgment of how the researcher's perspective and position have contributed to the construction of the research findings and the research process. Therefore, in qualitative research reflexivity is a crucial criterion for evaluation. This study has been evaluated in terms of both personal<sup>22</sup> and epistemological reflexivity. Prior to the data collection, a research committee approved of the study aims and the proposed research methods in order to ensure congruence. The research aimed to explore what lived experiences therapists have of working with borderline personality disorder in psychodynamic psychotherapy. The aims were met by recruiting and interviewing psychodynamic psychotherapists who had experiences with working with borderline individuals.

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<sup>22</sup> See the researcher's 'personal reflexivity' in section 4:2.7, on page 141.

Interpretative phenomenological analysis (IPA; Smith *et. al.*, 2009) was chosen as the research method, as it seemed to be the most adequate for meeting the aims of the study. The study was exploratory, as one unstructured and one semi-structured interview facilitated the exploration of participants' lived experiences and the small number of participants facilitated an in-depth analysis of the interviews. Thus, using IPA allowed the research aims to be met, and although there were a few limitations, as described below, this method seemed to be the most appropriate to employ for this exploratory research study. The research question has been answered by analysing and interpreting therapists' accounts of their lived experiences with a focus on the idiographic approach. The research question was, "*What experiences do psychodynamic therapists have of working with people with BPD?*"

#### 4:2.2 Epistemological reflexivity

The following two questions were proposed to evaluate the findings of this study from an epistemological position, "*Is there objective truth about what it is like working with people with borderline personality disorder, and, if so, can we identify it with precision and understand it through an exploration of therapists' experience?*" and "*Is therapist experience independent of the already existing knowledge in the literature or do both their experience and existing knowledge contribute to the construction of their meaning making?*"<sup>23</sup> Conducting a qualitative study allowed the participants to share their lived experiences with the researcher, and provided the researcher with in-depth and

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<sup>23</sup> See a description of the epistemological underpinnings of this study in section 2:2.2 on page 56.

rich information to examine whether there was an objective truth in therapists' account, and whether their experience was independent of, or influenced by the research literature on BPD. Quantitative research would not have been able to produce this type of knowledge.

First, there was no objective 'truth' found about the therapists' experience of working with borderline personality disorder. Although all the therapists experienced most themes, some themes were not described by each one of them.<sup>24</sup> Thus, it is possible that some therapists did not experience certain phenomena, which other therapists did. Alternatively, they might have experienced similar, or the same phenomena, but these experiences did not carry as much meanings for them as for those who reported such experiences. Thus, those experiences were not mentioned in the interviews. Furthermore, those themes, which were experienced by all the therapists, had individual meanings for each one of them. Not one therapist experienced the same phenomenon exactly the same way, although at times there were striking similarities between their accounts. Hence, it may be said that whilst each participant's individual experience was unique and particular, there were some shared and universal aspects of it. As Schleiermacher (1838) put it 'everyone carries a minimum of everyone else within' (p. 92-93).

Moreover, those therapists who worked with more than one patient either experienced the same phenomenon differently with different patients (e.g.

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<sup>24</sup> See a more detailed explanation of this in section 3:1.1 on page 67, in the paragraph beginning with '*Continuing the analysis with other cases*'.

‘negative counter-transference feelings’) or did not experience a phenomenon with all the borderline patients (e.g. ‘BPD label is rejected by patients’). These findings are consistent with the epistemological position of the study. That is, from a contextual constructivist’ perspective, the therapists various experiences were contextual and standpoint-dependent, because they facilitated different insights into the same phenomenon under investigation (Madill *et al.*, 2000). Similarly, the qualitative nature of IPA facilitated an in-depth exploration of the therapists’ subjective experiences, as opposed to predictive and objective investigations generated by quantitative methodologies. Therefore, while the findings reflected that all the therapists found this type of work ‘difficult and demanding’, which is consistent with some reports in the research literature, it is understood that their subjective interpretation and construction of meaning making of their experiences contributed to this difficulty rather than the nature of the condition itself (Spector and Kitsue, 1977). Thus, this study holds the view that the finding that working with borderline patients is difficult may not have been the therapists’ objective and ‘unified’ view, but it may have been based on their meaning making of their experiences.

Furthermore, counselling psychology is explicitly interested in the individual’s subjective experience, while it also recognises differences among human beings. Therefore, it is concerned with well-being rather than treatment, and it strives to understand rather than to seek ‘universal truth’ (Milton, 2010). A philosophical postmodern position suggests that drawing scientific conclusions within research and explaining things via ‘universal truth’ claims in psychotherapy might not be plausible, as human beings will undoubtedly have

unique experiences, and only one way of seeing things would leave many things unexplained. This may also raises ethical issues, because knowledge tends to be narrowed to exclude other different and diverse understandings and explanations (Rescher, 1993). Milton argues that as different models of psychological distress and change may all have validity, it is not necessary to reduce them to one 'unified' model of truth. Pluralism recognises that different perspectives have validity for different individuals at different times, and in the same way, different therapeutic theories will be helpful to different clients at different stages. In other words, there are 'many ways to health' (Lambert *et al.*, 2004, p. 809).

Second, while it seems that all the participants were well informed about psychological theories and some existing research publications reported about BPD in the literature, (e.g. negative counter-transference feelings; the significance of empathy and the therapeutic relationship), some of the findings in this study were not consistent with the literature (e.g. therapist stigma against borderline patients). In addition, there was no evidence found that certain themes reported here were investigated in any previous studies (e.g. therapist omnipotence). This implies that the therapists did not base their experiences solely on the publications in the literature. Rather, their experiences of working with borderline patients were based within the context of their psychodynamic work, while they used the research literature to inform themselves about BPD and to enhance their theoretical knowledge. At times therapists referred to, and did not agree with the existing literature. For instance, their experience of what BPD was as an 'illness' differed from the absolute definition of BPD, as described in the DSM-IV criteria.

Thus, these findings are a reflection of the earlier described epistemological debate, which argues that the DSM-IV criteria for BPD are located in objectivism, claiming objective and universal ‘truth’ about what patients with BPD might be like. On the other hand, while the therapists were aware of these criteria and at times found them helpful, their experiences were subjective, rather than objective, because they depended on their perceptions and interpretations of their experiences. Furthermore, the meaning of their subjective experiences was constructed out of their interaction with borderline patients within a psychodynamic environment rather than their awareness of the existing criteria for BPD, alone. However, it is also recognised and acknowledged that, to some degree, their existing knowledge about BPD may have influenced their meaning making of their experiences. Therefore, this study suggests that both the therapists’ lived experience and existing knowledge contributed to their construction of meaning making. This study also recognises that the therapist’s accounts of their experiences were affected by their interaction with the researcher and the social environment, as well as their experience of the phenomenon (Pontoretto, 2005).

Finally, the earlier described inevitable epistemological and ontological tension<sup>25</sup> is recognised in this study. This exists through the participants’ data between psychodynamic psychotherapists’ use of language and conceptualisation of their clients’ difficulties, as a realist and objective condition called BPD, and their construction of BPD, as a negative and stigmatising label, within the context of psychodynamic psychotherapy. This is because although

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<sup>25</sup> For a discussion of this see the third paragraph of section 2:2.1 on page 54 and in section 2:2.2 ‘Contextual Constructionism’ on page 56.



psychodynamic psychotherapists do not diagnose their patients and most of the therapists' patients in the current study did not have a formal diagnosis, therapists talked about their experiences of working with their patients in terms of assigning, with the help of their supervisors, their patients' difficulties to the condition of BPD. There was one exception where the therapist had patients who were given a BPD diagnosis by another mental health professional. Furthermore, while therapists employed the realist and objectivist language and condition of BPD, they also constructed the meaning of their experiences of working with 'BPD' as a diagnosis which was negative and problematic for their clients both within and outside psychotherapy.

On the other hand, counselling psychologists reject the dogma that individuals' difficulties are objective and can be reduced to the diagnostic categories, as they understand clients' distress as a product of interacting systems (Boucher, 2010). Therefore, it could be argued that the diagnostic nature of the title and the research question of this study might have been the reason why psychodynamic psychotherapists were more likely to participate in this study than counselling psychologists. It is believed that an awareness of this tension is important for those professionals who either work with this diagnosis in certain settings, or use such language without an existing diagnosis, within both the field of psychotherapy and counselling psychology.

*4:2.3. The contribution of the findings to the field of counselling psychology and psychodynamic psychotherapy*

This study contributes to the field, as it has demonstrated how qualitative methods, such as IPA, can develop rich contextual understandings of the experiential dimension of psychodynamic psychotherapists' experience through the use of an idiographic interpretative approach. This study recognises that qualitative research methods, as well as quantitative research methods, draw on certain assumptions about the world which can restrict the questions which can be asked (Milton, 2010). As human beings inevitably have a range of diverse and unique experiences, a preference for one methodological approach over another can be ethically problematic, as knowledge may be narrowed to exclude that which is unique and diverse in others (Rescher, 1993).

Thus, methodological pluralism, which embraces the diversity of methodological epistemologies and philosophies, fits with the philosophies of counselling psychology (Slife and Gantt, 1999). Methodological pluralism allows us to engage with complexity of issues and find the most suitable methodology for the nature of the problem being researched (Milton, 2010). Similarly, McLeod (2001) contends that only by incorporating different philosophical perspectives and postmodern research methodologies, will the field will advance in the context of both professional knowledge and societal impact (e.g. Hill, in press). This study has, therefore, chosen a qualitative methodology in order to produce the type of data and knowledge which can resonate for both counselling psychologists and psychodynamic psychotherapists and which they

can find useful for their professional practice. No other research employing in-depth interviews and investigation into these professionals' experiences of working with BPD has been undertaken before.

#### *4.2.4. The implications of the findings for the practice of counselling psychology and psychodynamic psychotherapy*

Counselling psychologists and psychotherapists, who work within a contemporary psychodynamic framework, both value the therapeutic relationship and the relational elements in psychotherapy, as well as the transference counter-transference paradigm and the therapist's role and qualities in this relationship (Rizq, 2008; Shedler, 2010). Therefore, the findings of this qualitative study may be applicable to the field and practice of counselling psychology, as well as psychodynamic psychotherapy, considering the fact that the participants in this study were all psychodynamic psychotherapists<sup>26</sup> and that the findings can not be generalised to other therapeutic professions<sup>27</sup>. First, it is proposed that those professionals who work with individuals who have a formal diagnosis of BPD must have an ongoing awareness of the significance, as well as the complications of both the therapeutic relationship and the relational elements in psychodynamic psychotherapy. For example, this study found that while the therapeutic relationship can be threatening to these individuals, possible negative counter-transference feelings can at times have implications for therapists' ability to empathise with and contain clients with BPD. Thus, psychodynamic

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<sup>26</sup> For a discussion of the similarities between the practice of counselling psychology and psychodynamic psychotherapy see section 1.2.3. vii, on page 40. For the differences between these fields, see page 131, in section 4.2.2.

<sup>27</sup> For a discussion of the similarities between the underlying epistemological position of this IPA study and the field of counselling psychology, see page 58, in section 2.2.2.

psychotherapists and counselling psychologists must find a way to manage these challenges.

This study suggests that one way to do this might be through reflexivity, where therapists need to monitor constantly their countertransference feelings and explore the ways in which they might contribute to the relationship within an intersubjective environment (Stolorow *et al.*, 1987). Another way to manage these challenges might be through ‘bracketing’ out their existing knowledge of the diagnosis of BPD and instead work with the unique and subjective experiences of the individual client, as the findings here revealed that clients can be sensitive to issues of labelling and stigmatising. Second, it seems that each phase of psychotherapy needs to be tailored to the borderline client’s individual needs. For instance, the findings here suggest that at times transference interpretations need to be withheld and the integration of cognitive and more supportive elements should be considered, which can be more containing for the borderline individual. In turn, this may also help therapists to manage those challenges and difficulties which they can face in their work with this patient population. Thus, a focus on an ethical relationship is required where the ‘otherness’ of the Other is respected (Levinas, 2003). This is in line with counselling psychologists’ pluralistic attitude (Milton, 2010).

Third, although neither counselling psychologists nor psychodynamic psychotherapists are trained to give any diagnoses to individuals with psychological distress, they often work in certain settings where clients come with a diagnosis of BPD. Thus, it is suggested that they must have an ongoing

dialogue with other fields, through engaging with those studies in the literature which provide the type of knowledge that can help therapists understand and conceptualise the psychological difficulties of the individual in a non-pathologizing way. For instance, a review of thirteen studies by Agrawal *et al.* (2004) has found evidence that there is a strong association between ‘insecure forms of attachment’ and the development of BPD, and has suggested that interpersonal instability is at the core of BPD. Furthermore, evidence found in Adult Attachment Interviews also suggests that secondary attachment strategies, such as preoccupied or hyperactivation attachment strategy (e.g. Patrick *et al.*, 1994, Shilkret, 2005) and dismissing or deactivation attachment strategy (eg. Shilkret, 2005, Dozier *et al.* 2008), may account for hypersensitivity and interpersonal difficulties in clients diagnosed with BPD (Schachner *et al.*, 2005).

This may have implications for practice when the therapeutic relationship has qualities of an attachment relationship and the therapist becomes a secondary attachment figure for clients, especially within the transference counter-transference dynamic. The findings here suggest that an awareness of the negative counter-transference responses and the bond between the therapist and client can inform therapists about the client’s early emotional experiences, and facilitate empathy and containment, as well as enhance therapists’ awareness of effective ways of being with the client. Thus, the attachment theory may enhance therapists’ existing knowledge of BPD from a relational viewpoint, as opposed to the DSM diagnostic categories, which do not allow for the appreciation of the individual’s phenomenological experiences (Crittenden, 2005). This way of conceptualising the difficulties of an individual who has a diagnosis of BPD

seems to fit in with the philosophies and ethos of counselling psychologists who recognise that psychological distress is a product of interacting systems (Boucher, 2010). Furthermore, they can also provide psychodynamic psychotherapists with a more appropriate account of how developmental relational experiences might contribute to risk factors underlying BPD (Barone, 2003). Finally, it is suggested that when there is no formal diagnosis of BPD, all therapists as well as their supervisors, should avoid attributing their clients' distress to the diagnosis of BPD and employing the language of 'psychopathology'.

*4.2.4.i The implications of the findings for the practice of MBT and TFP psychodynamic psychotherapy*

These findings can also inform those psychotherapists who practice within MBT, where the therapists focus less on transference interpretations and more on the attachment relationship between therapist and patient. MBT therapists use the attachment theory to inform themselves about the individual patient's difficulties with a diagnosis of BPD. Previous MBT studies have suggested that the core features of BPD are affect dysregulation, impulsivity and unstable relationships (e.g. Bateman and Fonagy, 2010). Fonagy and Luyten (2009) proposed that the difficulty in the borderline client's ability to distinguish between different mental states, their hypersensitivity and incapacity to integrate cognitive and affective elements of mentalisation account for these core features of BPD. Some therapists here experienced that a close therapeutic relationship can be threatening for those clients with BPD who need the bond and attachment

but who are also hypersensitive to any signs of rejection and abandonment. Thus, incorporating cognitive (e.g. explaining things from a different perspective) and supportive elements (empathising, containing and reassuring the patients) into the therapeutic work might be very containing for these individuals to deal with the affective aspects of the therapeutic relationship. In turn, this may strengthen the bond between the therapist and patient. MBT therapists may take these findings into account when they face similar challenges in their work with borderline patients in order to enhance their understanding about the individual's emotional experiences and interpersonal attachment relationships.

The implication of the finding here that labelling is problematic and can become a self-fulfilling prophecy for clients may be that MBT therapists can help patients mentalise about the meaning of their diagnosis in order to understand it as something that symbolises part but not the whole of their personality. Moreover, MBT therapists are aware that the borderline patient's profound anxiety can lead to overwhelming emotional experiences and the inability to read accurately others' motives. Thus, the failure to recognise the patient's sensitivity to interpersonal relationships can result in iatrogenic interactions in psychotherapy. Therefore, the findings here that the awareness and management of the therapists' negative counter-transference reactions and the possible obstacles in the therapeutic work, such as a patient's difficulty in bearing transference interpretations, is crucial in order to avoid iatrogenic interactions, as well as stigma, with this patient population might resonate for MBT therapists (Bateman and Fonagy, 2010).

On the other hand, TFP therapists may not take most findings in this study into account, as they employ strategies, tactics and techniques which seem to contrast with the present findings. First, while the results here indicated that patients with BPD found transference interpretations unbearable when they felt emotionally vulnerable, in TFP interpretations play a significant role in the treatment of BPD with the general analytic rule that they must be given to the patient where the affect is most intense, related to the patient's subjective experience, nonverbal behaviour or the counter-transference (Kernberg, 2004). Second, transference analysis is the focus in TFP where the analysis is associated with the patients' external reality so that the dissociation between the sessions and the individual's external life can be avoided (Kernberg *et al.*, 2008). In contrast with this, the findings in this study suggest that the therapist's 'being' with the patient might be more significant than 'doing' something to them. Thus, the current findings that the bond between therapist and patient and the patient's new experience of 'being' in the therapeutic relationship are more crucial than the analysis of the transference may not resonate for TFP therapists.

Third, technical neutrality has a significant role in the TFP treatment, as it counters the borderline individuals' tendency to externalise their intrapsychic conflicts (Kernberg *et al.*, 2008). Again, this seems to be in contrast with the findings here, since the therapist's role and empathy in the therapeutic relationship and their ability to contain the patients and their projections were of crucial importance. Thus, these findings suggest that interacting with the patients might be more effective than counteracting their behaviour. However, another significant finding in this study was that the therapists experienced strong



negative counter-transference feelings in the course of psychotherapy, with the implication that psychodynamic psychotherapists and counselling psychologists must have an ongoing awareness of their counter-transference feelings and responses when working with individuals with BPD. This seems to resonate with the theory and practice of TFP, in which the therapist's counter-transference feelings are believed to be very effective ways of informing the therapist about the patient's underlying conflicts and difficulties (Kernberg *et al.*, 2008).

In conclusion, the findings of this study may inform counselling psychologists and psychotherapists trained within any type of psychodynamic psychotherapy about the specific types of difficulties and obstacles, which therapists can face when working with borderline patients within the psychodynamic modality, as well as those factors which can be unique and significant to their work. Furthermore, this study offers some ways of managing these challenges in psychotherapy and a relational view of conceptualising BPD in a non-pathologising way. By doing this, it is hoped that therapists might enhance both their theoretical and practical knowledge, and develop more effective ways and better coping strategies for working with BPD in psychotherapy. In turn, this could encourage psychodynamic psychotherapy and counselling psychology training courses to educate their trainees about working with this specific patient population within the psychodynamic context.

#### 4:2.5 Limitations of IPA

This study has a number of limitations. First, the difficulties in recruiting counselling psychologists meant that a convenience sample consisting of

psychodynamic psychotherapists was the best option. Thus, homogeneity could be an issue, as psychodynamic psychotherapists can have different theoretical orientations and focus, whereas counselling psychologists usually work relationally with their clients. It might have been good to recruit therapists within different professions to collect data from a wider range of experiences. However, there is recognition that this may have also been an issue due to differences in psychodynamic training amongst psychotherapists (i.e. see earlier point). Second, the researcher's inexperience in IPA may have limited the depth of the interviews and the richness of the analysis. Although the hope was that there was a gradual improvement during the research process.

Third, the sample size in this study could be perceived as a limitation however, it was in accordance with the use of IPA (Smith *et. al.*, 2009). The sample was intended to be homogenous, rather than representative. Consequently, the findings cannot be generalised, as the therapists' experiences were idiographic, subjective and contextual with no objective 'truth' found about what it is like working with borderline patients. Hence, the results in this study were based on five participants' accounts, and may or may not apply to other therapists' experiences. As contextual constructionist research is contextual and stand-point dependent, the focus is in on completeness, rather than accuracy of representations (Crotty, 1998). However, it may be inferred that these kinds of experiences can happen within psychotherapy when working with BPD. More research is needed with similar and other therapist groups.

Fourth, all participants in this study were female. A previous qualitative study of clinicians' experiences of working with BPD reported that female practitioners had more positive attitudes towards borderline clients than their male counterparts (Commons Treloar and Lewis, 2008). Thus, the implications for the current findings, if both women and men had participated in this study, could have been that male participants might have had less empathy and more negative attitude towards patients with BPD. However, the current findings suggest that at times female practitioners found it difficult to have empathy or 'positive attitude' towards their patients. Thus, it may be argued that due to a more homogeneous sample in this study, where all participants were psychodynamic practitioners, as opposed to a non-homogeneous sample in the previous qualitative study, where practitioners worked within either the emergency medicine or the mental health field, the gender of the therapists here may not have played a major part in the findings.

Fifth, IPA as a research method has its limitations. The participants made meaning of their lived experiences, using language. In describing their experiences, the participants may have constructed a new reality in order to appear as they wished to the researcher. Furthermore, some participants' choice of words and inability to be articulate may have not been an accurate reflection of their feelings or experiences (Willig, 2001). Some participants seemed to be anxious during the interview, as they used pauses frequently and rephrased their answers, which implies their attempts to give 'perfect' replies, instead of answering the questions from the top of their head. It is possible that at times the participants found it difficult to describe their experiences of working with

borderline patients due to the interview process. Van Kaam (1959) proposed that it is vital that a person is understood by the other in a conversation and feels safe in a relationship, in order to have a good experience of the interaction. While the researcher attempted to provide these experiences to the participants, it was not always possible to achieve this with every interviewee and throughout the two whole interviews.

Furthermore, it may also be possible that the interactional process of the interviews influenced the responses offered by the therapists. Wooffitt and Widdicombe (2006) criticise qualitative research, specifically IPA, because there is a lack of appreciation of the manner in which the utterances of the interviewer affect particular replies from the participants. Moreover, the therapists' awareness of ethical guidelines may have affected their disclosure of some information about their patients, which were incongruent with the guidelines. Last, but not the least, it is questionable how much an interview can discover participants' lived experiences of a phenomenon and how well transcription of the interviews is a reflection of what participants intended to say (Kvale, 1996).

#### 4.2.6 Future developments

According to Smith (1999), the results of an IPA study cannot be considered as '*final statement on the matter*' (p. 296), because they do not represent the general population, due to a small number of participants. Therefore, recommendations of an exploratory study are not appropriate. Instead, subsequent research of the same phenomena should be undertaken to elaborate

on the results. For instance, further research might be done to investigate whether an integrative model would be more suitable for working with borderline patients, as no previous research has yet focused on this. Alternatively, further research might employ an in-depth exploration of certain themes (e.g. ‘bond between therapist and patient’ or ‘difficulty in accessing empathy’) highlighted in this study to have deeper understanding of the significance of these concepts. Finally, it would be interesting to interview borderline individuals, who have a psychiatric diagnosis, to gain a better understanding of their experiences of what it is like being in psychotherapy, as patients with a diagnosis of BPD. A particular interest might be of patients’ experiences of the therapeutic relationship and the effects which patients’ awareness of having a BPD diagnosis have on their recovery process.

#### *4.2.7 Personal reflexivity*<sup>28</sup>

The purpose of personal reflexivity is to reflect on who I am as a researcher and to identify what factors may have influenced and contributed to this IPA study on my part. I believe these were my influences on the data as a person, as interpretations are the result of me: my limited experience as a trainee counselling psychologist with borderline patients; my extensive readings on BPD and; my experience of the participants during the interviews. Although IPA suggests that the researcher’s beliefs and preconceptions should be ‘bracketed’ out during the analysis of the data (Husserl, 1927), it also acknowledges that this

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<sup>28</sup> I write in the first-person view as I feel that this is more appropriate for reflecting on my personal journey as a researcher; as opposed to the third-person view, which allows for a more professional presentation of my research throughout the thesis.

is not possible to do completely. I sometimes found it difficult not to approach the data from mainly my own experience of working with two borderline patients. I have experienced that patients diagnosed with BPD can struggle with relationships and at the same time crave closeness, and can suffer a great deal of pain, because of their awareness of their diagnosis and its stigma. I felt a lot of compassion and empathy towards these individuals. The fact that therapists in this study revealed very similar experiences to mine, without me sharing my experiences with them, made it easier for me to hold back my own beliefs and preconceptions during the interviews and the analysis of the data.

I feel that conducting the interviews was one of my weaknesses in this study, as I was rather directive with the first two participants, due to my anxiety, my lack of experience as an IPA researcher and the participants' expectations of what an interview might be like. I now know that I should have explained the nature of the interviews better to the participants. However, the second interview felt more natural with each participant due to a rapport having been built in the first interview and the gradual improvement of my overall interviewing technique over time. Another weak point might have been that I did not ask for feedback from the participants to ensure validity of my findings. First, I contemplated sending my results to the therapists to validate my understanding of their experiences, but later I decided against it. This was because IPA focuses more on how meaning is constructed from the researcher's perspective and position, on basis of the participants' accounts, rather than how meaning is constructed solely from the participants' perspective and position (Willig, 2001).

My positive experience of this research was that interviewing the same participant twice allowed me to have a bond with them, which facilitated greater trust between us and thus enhanced the therapists' disclosure. Although I offered money to them at the end of the second interview to thank them for their time, it did not feel that it was an exchange for the interviews. In fact, some therapists did not wish to take the money, despite our initial agreement, and decided to donate it to a charity. I also greatly enjoyed the creative part of the data analysis; coming up with the themes and the master themes of the study, which were also presented to, and evaluated by an IPA group I attended, and writing up the final results of the findings. I feel that my research process developed well over the last one year, during which time I have learnt a lot about research as well as gained an insight into what it might be like for psychotherapist to work with a very vulnerable and heavily stigmatised group of patients. Having had a quantitative research background I have mainly come to realise that qualitative research can be a very valuable, creative and meaningful experience.

Finally, I recognise that my way of interpreting and analysing the data in this research study was just one approach to understanding the therapists' lived experiences (albeit one I have found to be helpful and enlightening), as there are many other possible ways of understanding and meaning making.

#### *4.2.8 Conclusion*

This study has attempted to illustrate how an idiographic approach illuminates psychodynamic psychotherapists' lived experience of working with borderline personality disorder. The understanding of this phenomenon is significant for improving therapeutic work with this patient population and enhancing care for these individuals. IPA is a valuable contribution to qualitative research, which facilitates the in-depth understanding and the detailed analysis of the individual's subjective-felt experience. As discussed above, little or no previous studies in this field have investigated this so far.



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## *Appendix 1*



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### *Information sheet*

*“Therapist lived experience of working with borderline personality disorder in psychodynamic psychotherapy: an Interpretative Phenomenological Analysis.”*

You are asked to participate in a research study conducted by Isabel T Marozsan, PsychD research student and trainee counselling psychologist, at Roehampton University, London. You were selected as a possible participant in this study because you were interested in participating in the research and you fit all the required criteria. Your participation in this research study is voluntary.

#### **Why is this study being done?**

This research study aims to investigate counselling psychologists’ experience of working with borderline personality disorder within a psychodynamic model.

#### **What will happen if I take part in this research study?**

An unstructured and a semi-structured interview schedule will be used to conduct face to face interviews. The interviews will take place at The Stress Project mental health organisation in London or at a place that the participant chooses. The interview will be audio taped. Certain personal details (such as age, gender and the length of time you have been working with borderline clients) and any other distinguishing features that should be disclosed in the interview will be made anonymous at the point of transcription. During the interview, you will be asked questions from the interview schedule as well as further questions that emerge from the conversation and allow you to elaborate your answers. Questions will include: “Can you tell me about your experience of working with people who have borderline personality disorder?” “Could you say more about that?” “How did that make you feel?” You will have the option of declining to answer a question at any point during the interview.

#### **How long will I be in the research study?**

The interviews will last approximately 60 minutes each (and 10 minutes for the introduction & debriefing). This may be subject to change, due to the flexible nature of the semi-structured interviews, which allows for the emergence of new questions during the interview, as a result of what you say.

**Are there any potential risks or discomforts that I can expect from this study?**

There is a significant risk that you may find talking about your experience of working with borderline clients upsetting or unnerving in some way. The researcher will endeavour to make sure that you fully understand the nature of the research and will verify with you that if at any time during the interview you feel uncomfortable, you are free to say so with no detrimental consequence to yourself. The researcher will include a list of sources of emotional help and support groups available to all participants.

**Are there any potential benefits if I participate?**

The results of the research might bring awareness to both the medical profession and the field of counselling psychology, in order to provide counselling psychologists and psychotherapists with further information about working with BPD in a psychodynamic setting.

**Will information about me and my participation be kept confidential?**

Any information that is obtained in connection with this study and that can identify you will remain confidential. It will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of removing all personal details (i.e. age, gender) at the point of transcription. Those which can not be removed will be treated as confidential and anonymous. They will be kept in a secure place until the examination period is over and for the following 10 years afterwards. This will be in accordance with University policy.

**Withdrawal of participation by the investigator**

The investigator may withdraw you from participating in this research if circumstances arise which warrant doing it so. If the researcher feels that you are in any danger or risk, due to emotional difficulties in the interview, you may have to drop out, even if you would like to continue. The investigator will make the decision and let you know if it is not possible for you to continue. The decision may be made in order to protect your health and safety.

**What are my rights if I take part in this study?**

You may withdraw your consent at any time and discontinue participation without penalty or loss of benefits to which you were otherwise entitled. You have the right to withdraw at any time without giving a reason via quoting an 8-digit ID number (ABCD1234). However, your withdrawal might have implications, as the data in an aggregate form may still be used or published.

You can choose whether or not you want to be in this study. As you volunteer to be in this study, you may leave the study at any time without consequences of any kind. You are not waiving any of your legal rights if you choose to be in this research study. You may refuse to answer any questions that you do not want to answer and still remain in the study.



**Will I be informed of the results when the research project is finished?**

If you wish to know the results of the research project once it has been completed, the researcher would be happy to send you a letter explaining the overall findings.

**Who can answer questions I might have about this study?**

If you have any questions, comments or concerns about the research, you can talk to the researcher. Please contact the researcher at [isabelmarozsan@hotmail.com](mailto:isabelmarozsan@hotmail.com) or 07737305848.

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Dean of School (or if the researcher is a student you can also contact the Director of Studies.)

**Director of Studies Contact Details:**

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## ***Appendix 2***

### ***Screening questionnaire***

#### *Research inclusion & exclusion criteria*

I hereby confirm that

I am either a BPS chartered counselling psychologists or a BACP, UKCP or BPC chartered psychotherapist

I have at least 3 years post-qualification experience of working with people with borderline personality disorder

I am currently practising in the psychodynamic or psychoanalytic model

I am working in a voluntary setting, private or National Health Service (NHS)

I have either seen my borderline client for at least 20 sessions or have recently finished therapy with him/her.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### *Appendix 3*



#### ***Counselling Research Participants Needed!***

*“Do you have any experience of working with people with borderline personality disorder?”*

A PsychD research student and trainee counselling psychologist, at Roehampton University, is looking for therapists to participate in her research study. The *aim* of the study is to investigate what experiences psychodynamic psychotherapists have with people with borderline personality disorder.

*Therapists* must be BPS chartered counselling psychologists or BACP and UKCP accredited therapists, with at least 3 years post-qualification experience, currently practising in a psychodynamic or psychoanalytic model; working in either a voluntary setting, private or National Health Service (NHS); have experience of working with clients who have borderline personality disorder; have either completed counselling with a borderline individual or are currently seeing clients who have had at least 20 sessions of therapy.

All participants would be required to participate in one *unstructured* and one *semi-structured interview* which will last approximately 60 minutes. You will receive £20 for each interview as *payment* for your participation but you will not have any other direct benefits from your participation in the research. The results of the research might bring *awareness* to both the medical profession and the field of counselling psychology and psychotherapy, in order to provide counselling psychologists and psychotherapists with further information about working with BPD in a psychodynamic setting.

If you are interested in participating and think that you suit the criteria or if you have any questions, comments or concerns about the research, please *contact the researcher* at [isabelmarozsan@hotmail.com](mailto:isabelmarozsan@hotmail.com) or 07737305848.

## *Appendix 4*



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### ETHICS BOARD

### INFORMED CONSENT FORM

**Title of Research Project:** *“Therapist lived experience of working with borderline personality disorder in psychodynamic psychotherapy: an Interpretative Phenomenological Analysis”.*

#### **Brief Description of Research Project:**

The aim of this research is to explore therapist experience of working with borderline personality disorder (BPD) in psychodynamic psychotherapy. Many health professionals find working with BPD difficult and even avoid working with people who are diagnosed with this condition. Drawing on the results of previously reported studies in the research literature and, what seems to be, a lack in qualitative studies investigating therapist experience of working with BPD, this study will use an interpretative phenomenological analysis method to investigate this phenomenon. This study may have both theoretical and practical implications for the approach counselling psychologists and psychotherapists take towards working with clients with BPD in psychodynamic psychotherapy.

The study involves two one-hour interviews; an unstructured and a semi-structured interview. The interviews will be audio taped. Certain personal details (age, gender and the length of time therapists have been working with borderline clients) and any other distinguishing features that should be disclosed in the interview will be made anonymous at the point of transcription. During the interview, you will be asked questions from the interview schedule as well as further questions that emerge from the conversation in order to allow you to elaborate on your answers. You will have the right to withdraw at any time without giving a reason, via quoting an 8-digit ID number (ABCD1238), which will also appear on the debriefing form. However, the withdrawal might have implications, as the data in an aggregate form may still be used or published.

The written up research thesis will only be read by the examiners of the Research Board and nobody else. Should the thesis get published, I will send you a copy of the thesis first to read it through. Should you find any information in the thesis,

which might identify your patient, you will have the right to voice your worry and to ask me to change or remove those information.

**Investigator Contact Details:**

Isabel T. Marozsan  
Counselling Psychology Department  
School of Human & Life Sciences  
Whitelands College  
Roehampton University  
Holybourne Avenue  
London  
SW15 4JD

**Consent Statement:**

I agree to take part in this research, and am aware that I am free to withdraw at any point. I understand that the information I provide will be treated in confidence by the investigator and that my identity will be protected in the publication of any findings. Confidentiality will be broken if the I reveal information that suggests 1) I am a danger to myself or others 2) there is an ethical issue 3) legal reasons. This is in accordance with *The British Psychological Society Code of Ethics and Conducts (2009)* guidelines. I also agree to the interview being audio taped and the interview material used. I understand that I have a right to withdraw from this consent at any point of the interview, via quoting an 8-digit ID number (ABCD1238). I do understand that the withdrawal might have implications, as the data in an aggregate form may still be used or published.

Name .....

Signature .....

Date .....

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Dean of School (or if the researcher is a student you can also contact the Director of Studies.)

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***Appendix 5******The participant's personal details***

Name:

Age:            20-30        30-40        40-50        50-60        60-70        70-80

Gender:        Male            Female

Experience:            years

The number of sessions I have had with my client:

The date I finished therapy with my client:

## ***Appendix 6***

### ***The interview schedule***

#### *Interview 1: Unstructured interview*

Question 1: *“Could you please tell me if you’ve got a client who’s got a condition called borderline personality disorder (BPD) at the moment?”*

Question 2: *“How long have you been working with him/her?”*

Question 3: *“How did you get into this line of work?”*

Question 4: *“Would you tell me what experiences do you have working with this client?”*

Follow-up questions to investigate the participant’s experience in more detail.

For instance: *“What do you mean when you say that?”*

*“Would you care to say more about that?”*

*“How does that feel when your client does that?”*

#### *Interview 1: Semi-structured interview*

Questions are based on the data in the previous interview. Thus, these questions were different for each participants. The following questions are examples of the questions which were asked.

For instance: *“Last week you talked about your negative countertransference feelings in your work with your patient with BPD. Could you please say more about this in more details?”*

*“In the first interview you mentioned that your patients find interpretation difficult in psychodynamic therapy. I wonder if you could elaborate on that.”*

*“Last week you said that empathy is important, but you could not always access it with this patient population. I wonder what you meant when you said that.”*

*“I wonder if I could ask you to talk a bit more about the therapeutic relationship between you and your client, as last time I understood that it was important in your work.”*

## *Appendix 7*



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### **Debriefing form for the Study entitled:**

*“Therapist lived experience of working with borderline personality disorder in psychodynamic psychotherapy: an Interpretative Phenomenological Analysis”*

Dear Participant,

ID number: (ABCD1234)

Thank you for participating in the preceding study. During this study you are asked to describe your lived experience of working with borderline personality disorder in psychodynamic psychotherapy.

You are reminded that your original consent document included the following information: “I agree to take part in this research, and am aware that I am free to withdraw at any point. I understand that the information I provide will be treated in confidence by the investigator and that my identity will be protected in the publication of any findings. Confidentiality will be broken if the participant reveals information that suggests 1) they are a danger to themselves or others 2) there is an ethical issue 3) legal reasons. This is in accordance with *The British Psychological Society Code of Ethics and Conduct* (2009) guidelines.”

You have the right to withdraw at any time without giving a reason, via quoting your 8-digit ID number (ABCD1234), which appears on top of this form. However, the withdrawal might have implications, as the data in an aggregate form may still be used or published.

If you have *any* questions regarding this study (its purpose or procedures), your participation in this study (the data you provided in the light of disclosure) or if you are interested in obtaining a copy of the final report of this study, please feel free to contact the primary investigator, Isabel T Marozsan at [isabelmarozsan@hotmail.com](mailto:isabelmarozsan@hotmail.com) or 07737305848. Alternatively you might like to contact my Director of Studies at [s.farnfield@roehampton.ac.uk](mailto:s.farnfield@roehampton.ac.uk) or (020) 83924505.

*The interviewer will offer some time after the interview, should you require to discuss any issue that has arisen in the interview.*



*If you feel a need to speak to a professional concerning any uncomfortable feelings from your participation in this research or if you have experiences distress as a result of your participation in this study, please see a referral list of mental health providers below for your use. (Please remember that any cost in seeking medical assistance is at your own expense).*

**Association of Therapeutic Communities**

Tel: 01242 620 077

Web: [www.therapeuticcommunities.org](http://www.therapeuticcommunities.org)

**The British Association for Counselling and Psychotherapy (BACP)**

Tel.: 01455 883300

E-mail: [bacp@bacp.co.uk](mailto:bacp@bacp.co.uk)

Website: [www.bacp.co.uk](http://www.bacp.co.uk)

**British Psychological Society (BPS)**

Tel: +44 (0) 116 254 9568

E-mail: [enquiries@bps.org.uk](mailto:enquiries@bps.org.uk)

Web: [www.bps.org.uk](http://www.bps.org.uk)

**United Kingdom Council for Psychotherapy (UKCP)**

Tel: 0207 0149955

E-mail: [info@ukcp.org.uk](mailto:info@ukcp.org.uk)

Web: <http://www.psychotherapy.org.uk/>

Please again accept my appreciation for your participation in this study.

<i>Name</i>	<i>Date</i>
-------------	-------------

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Dean of School (or if the researcher is a student you can also contact the Director of Studies.)

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## *Appendix 8*

### *List of all the master themes & their super-ordinate themes (Including an illustrative extract for each theme and their page number/s)*

#### **Master theme 1 – Negative counter-transference feelings- 4 sub-themes**

##### **1) Hopelessness**

*“Mmmm... I feel... hopelessness...uhmm...quite a kind of nihilistic sort of despair...not...not a sadness... a kind of despair that...this matters would really, I suppose, would improve for the client.” (Maria, Interview 1, pg. 7)*

*“I think it’s also this type of work is often a little bit hopeless. Because you’re getting into the... (sigh)... the real despair... and their loss. And I think, you know...that bit tends to get a bit hopeless... but often they do go away with something, you know...” (Melanie, Interview 1, pg. 16)*

*“There’s helplessness and hopelessness, you know, validating how she feels, which she can’t stand she absolutely finds it as completely horrible... It does sort of feel very much like bringing somebody up, trying to make them to be a different person... by just telling them how to be.” (Agnes, Interview 1, pg. 7)*

*“I felt I was really trapped feeling quite despairing and ‘Oh, God, I just cant think of any more of what to say and what I might say that might make a difference’... that was even hopelessness more than hatred.” (Leah, Interview 1, Pg. 16)*

##### **2) Inadequacy**

*“...but I think she did...she experienced me saying ‘Go to someone else’...she experienced me as not being able to contain me...as me not being enough for her...and me probably...her then probably successfully killed me off.” (Maria, Interview 1, pg. 6)*

*“Well... I go to my supervisor...which is very very helpful...it always puts me to a place of my own insecurity, as a therapist....because often that’s been thrown at me that I’ve been unprofessional, useless and I’ve done this wrong and that wrong. So, uhmmm...for me, my supervisor, in a sense, is normalising and being very...uhmmm...I tend to say supportive...uhmmm...the normalising, I think, is the most important thing...that there wasn’t something, well not with me, I wasn’t a bad therapist...uhmmm...help me move to...to somewhere...I guess, you know, it was running its course.” (Helen, Interview 1, pg. 8)*

*“I think I feel like ‘Yeah, I might be up to the task’, but, you know, when my own counter-transference kicks in, you know, my own kind of wanting to be the best, you know, wanting to be the one person who does it...so, it also kind of gets me going as well, I wanna be the saviour...uhm... but, then I also, on the other hand, I get the fear that I’m not good enough. Because in my experience of borderlines is that...no matter how much good they get later on it’s not quite enough.” (Melanie, Interview 1, pg. 4)*

*"I suppose I... I suppose it just makes you feel inadequate and that you are not giving...that you are not the right kind of therapist, you are not being any good for them... you're wasting that time. I think it just... I think that it just undermines... it just undermines the work, because you... you... feel so powerless and that's something borderline people do to you... to make you feel completely useless. So, that's really important that you're aware of your counter-transference, because otherwise you just think that you're a bad therapist." (Agnes, Interview 1, pg. 17)*

### **3) Difficulty in containing feelings**

*"Sometimes quite profoundly, because it's very... I'd say I can feel quite killed off by them... so, trying to think in the room when somebody is trying to obliterate you is... is... it can be really hard...and it...it can be really...very physically tiring. So, it definitely is how a lot of them... thinking about the work reflectively...is often how you can withstand them or how can you... find it... to bring something into that." (Maria, Interview 1, pg. 4)*

*"What she makes me experience, I think she subjects me to...uhm... such tirades, such horrible experiences, sometimes of being at the receiving end of someone who is very overwhelming and intrusive and swears and pushes me, knows even that sometimes she is pushing me, I know that she wants me to feel the kind of, feel hurt by the way she is speaking to me. Uhmmm... and it takes all my strength sometimes not to just say 'Sorry, I really don't think I can help you'. Uhmm... it's so hard to be with her.. and when she goes into these states, she physically changes, the way she looks, the way she speak. She becomes like a grotesque figure that's really quite frightening." (Leah, Interview 1, pg. 14)*

*"I feel...uhmmm...well, I think I go numb, actually...in the sense of protecting myself...I...yes...yes...I am receiving the gunshots but I'm also rendered sort of speechless...don't know what to say...uhmmm...so, I just, I try and not express anger with her, I try not to retort, but I think for me, it's... I always go into my 'I need to survive mode'. Uhmmm.. Well, in the session, I think, part of me steps out, probably out of the room...and it's slightly like holding my breath...or...for the entire session." (Helen, Interview 1, pg. 7)*

*"....When she starts talking about him and how he is behaving and what she's trying to do, I panic. That's how, that's the emotion she really puts into me, I can feel my heart racing, I feel very very panicky, because I think this situation is so awful and he is so awful and what she's describing is so awful, I don't know what to do. And I get really anxious about that to the point of panic....now I make an effort not to have him in the room, because I cant cope with him.. And that's obviously a counter-transference, that's another... that's her again." (Agnes, Interview 1, pg. 18)*

*"...I had to really, you know, take a step back and say 'Ok, maybe I got it wrong'. Because the reaction was so aggressive that I actually couldn't handle the aggressive reaction....I always felt on edge around her... I can generally contain it. Unless it is very very strong then...or if I'm in a particularly bad place that day that'll have an effect..." (Melanie, Interview 1, pg. 15)*

#### 4) Cognitive abilities affected

*“...she was draining because she just...her mind was like a blank. I found it really, really hard to...to literally have images and thoughts in my own mind when I was in the room with her. uhm...so, she was...I felt sort of...sort of weighed down by her.. so, I’m flat....I find the best thing for me working with borderline people is always to...to get help actually...from my supervisor or my peer group...because I find them the most difficult people to think about and to think of what they’re doing to me and all of that...it’s very difficult to think about on your own.” (Maria, Interview 1, pg. 8 &14)*

*“.. and there were particular other experiences I had in the first meeting with him, like the difficulty of remembering what happened in the meeting... I would call that a counter-transference phenomenon, whereby the impact that he had on me, which was to rather scramble my mind. It’s a fear with the usual functioning of my mind.... It alerts me also that someone has had a particular impact on my mind and that I find it particularly difficult to remember...uhm..” (Leah, Interview 1, pg. 5)*

*“I’ve to keep her (ex-wife) out because I feel so helpless. Because you cant really think... there’s no way of really thinking around the situation, because the presence of her is so absolutely enormous, it’s too difficult thinking about that.” (Agnes, Interview 1, pg. 19)*

#### Master theme 2 – “Sitting in the dark together” - 4 sub-themes

##### 1) Bond between therapist and patient

*“I think it’s...we call it... a deep connection and it can be something very small that will cause quite a big change..... I’ve seen this borderline person recently always acting out... and then in one session she just said something about her sister ‘She’s like this and that’ and I said ‘Well, you may feel that but I actually hear her saying that she’s protective that she wants to protect you...sounds like it’s from a caring position.’ And that’s it, from then on, literally that one sentence and she has...it’s completely changed the relationship... And I’m thinking ‘Huh? How did this happen?’“ (Melanie, Interview 1, pg. 22)*

*“I’m just thinking of something that I’ve recently had to do...and how...many of the more borderline patients could stay away and...you know, after he was absent for three sessions, I write a letter saying, you know... ‘Since you’ve not been able to attend since my cancellation on such and such day and I hope you... I’ll see you on Friday’, kind of thing... And he came back and said ‘I’m here because of your letter. I didn’t expect such a letter.... Yes, I certainly think this is how the process strengthened...the sense of alliance with this particular patient.” (Leah, Interview 2, pg. 4)*

*“I think he needs to think...he needs to be able to relate to me, to things that are good for him, and I think that’s what the being the begader was, because he talked about his experience in the army and that obviously is a very very very good experience for him and I think he wanted me to be tied to something that was good.” (Agnes, Interview 2, pg. 20)*

*"I actually offered for her if she wanted to email me in the week. I wasn't prepared to speak to her or anything like that. Because I thought if it's helpful to her, that's okay....and she didn't'. And that's what's very interesting. That if I almost anticipate something or offer it or whatever...and she often...it's the offering that matters rather than..." (Helen, Interview 1, pg. 16)*

## **2) Significance of 'Being' rather than 'Doing'**

*"Yeah. .. Uhmm... I want to be allowed to be with them. I want to be allowed to connect with them. yes, I want to be, I suppose, allowed...I'd like... I see it as... as a progress, I suppose for them. if they relay would allow the relationship to happen...the relationship to...uhmm..to have any meaning...yeah, an effect on them in any way, rather than the relationship ultimately being regarded as destructive or..." (Maria, Interview 1, pg. 13)*

*"Uhmmm...but there's something with this client that has... at some level I've let go of 'I must get it right and do it...'. You know, I must come up with the interpretation that's going to change... I very much just sit and sometimes I do reflect back. So, I... for me, it's really... I don't really try to change anything, I just try to be with." (Helen, Interview 1, pg. 3)*

*"Because we certainly don't focus on the symptoms more directly...you know, we...we...the symptoms often improve through the process. We don't focus on the symptoms. We focus on the emotional process that's developing with the patient between therapist and the patient." (Leah, Interview 1, pg. 13)*

*"...Uhmm..... uhmm.. it's that connection that matters more than anything else. Somebody being able to sit with you in the dark, rather than trying to push you out of the dark, I think that's... that's what I find helpful. If that makes sense." (Melanie, Interview 1, pg. 13)*

*"Yeah, I... I think there is something strange of his experience of me ... and obviously all clients experience one in a different way but in all those other ways I still feel that I'm... they're experiencing me as a therapist... they're experiencing me... an aspect of me and with him, I feel that it has a slightly fantastic feel about it. Uhmm.. that I am sort of in a role... I'm not quite sure what it is." (Agnes, Interview 2, pg.18)*

## **3) New experience as template for relating**

*"I suppose I'd say that the relationship is about...it's about enabling them to realise that there are relationships...to be that in the world, as opposed to a sort of fractured, isolated kind of understanding of that. Uhmm...and actually to contain them so that they can function in society, because obviously they do kind of have problems with employment and other people and..." (Maria, Interview 1, pg. 14)*

*"I think if she can accept me when I made a mistake then...yeah, that's absolutely crucial. Absolutely crucial. Not only because of her experience of other people, but because of her experience of herself. You know, she's either useless, or she's...perfect. It's modelling it in a way, yeah." (Helen, Interview 2, pg. 11)*

*"I suppose, in another aspect what they come to learn is that I'm not perfect. I don't get things right all the time, I don't...you know...I do misunderstand them sometimes or...and that...that is also a part of the process of...what...it's quite an important part of what they might learn from the process, to be less harsh with themselves." (Leah, Interview 2, pg. 8)*

*"But clients I've seen, they do go away with something. I think their experience of a good relationship I think and an attachment where, which hasn't been abusive, which had been boundaried, has been caring, uhmm.. which has been a good ending.... I just think having another experience itself is helpful....so I don't know if you can treat it as such. But I think you can give a better experience." (Melanie, Interview 1, pg. 17)*

*"I think he thinks he's coming to me for something that I'm supposed to be giving him. And if I start saying that I am frustrated or disappointed or whatever, I think he thinks that as a bit of an element. I don't think he would think that it's a response to what's going on for him. I mean...maybe that's something I need to think up, because that might help him...help relate to himself and relate to other people if...if...if...if I talked to him about how I felt." (Agnes, Interview 1, pg.24)*

#### **4) Empathy is crucial**

*"...I think, I think more about...to me empathy is a sort of deep attending to someone when someone is at that state.... I think empathy is absolutely a sort of root and branch of my style....I think my...my...my associations of empathy is someone sort of...sort of caring and then.. and then, you know, well, probably all my client work is slightly more than alongside. I think it's sometimes...uhmmm...not inside, in an intrusive, you know, take you anyway, but I think slightly more... (indecipherable)." (Maria, Interview 2, pg. 7)*

*"...I think when you...you know that what's... that's happening to you is what...it's him, it can make...it can only enhance your understanding what it's like to be in his head, because you're practically experiencing it yourself. You know, it's really making the experience of being him incredibly real. I am not just empathising with him... I'm experiencing him." (Agnes, Interview 2, pg. 15)*

*"Uhhmm...of course, there're all kinds of ways, in which your patient gets you to know what it's like to be them...the telling that comes to mind first but there are other ways of getting you to know that....some of which are much more unconscious processes, we call them projective...call it projective identification, where the patient puts you the therapist, in the position of...of in a way, a position they were in, maybe, as a child. I really get to know what it's like to be this patient. So, that's how...empathy is, I think, that it's about knowing all that and it takes time to process your feelings enough to find a position, form which you can talk to the patient about.. in a way, you're talking about your own experience, if you've empathised in this deep way." (Leah, Interview 2, pg. 10)*

*"But often it's not like that, it's more unconscious projections of certain feelings that they feel are intolerable. In a way, I think it's part of the process of empathy, in a way.. See, I don't connect empathy so much with positive feelings*

*necessarily...maybe, most people do... I think part of empathic response does mean that I have to be open to experiencing feelings that are really unpleasant.” (Leah, Interview 2, pg. 12)*

*“I think having empathy as a core is really important and certainly...I’m informed by psychodynamic... but I’m certainly person-centred in the room. And I think for this group it really helps because...especially if they’ve been acting out as well as...they’re angry and frustrated...they need someone to see the pain.” (Melanie, Interview 2, pg. 16)*

*“I just really had...had some real gut feelings in response to what she was saying of usually hopelessness or despair. Not my hopelessness particularly, but just how dreadful...uhmm.. life is really... and what a struggle... I think it’s important that somebody feels heard and understood...understood being more important...uhmmm...without judgment...uhmm...I mean, and I don’t think therapy stops at that point and I do sometimes, with this client she’ll say something and there is a lot of truth in it, but she makes so many assumptions about other people’s lives or their experiences or how they see her and I do challenge that from time to time. And often, that’s been quite an eye opener...for her.” (Helen, Interview 2, pg. 11)*

### **Master theme 3- Hindrance in therapeutic work- 4 sub-themes**

#### **1) Significance of modifying the psychodynamic model**

*“...I think probably it’s worth kind of, at the beginning of the work, kind of...you know, trying to put in something quite cognitive, if you like, to encourage to positive transference. Because if you allow yourself just to be set up in a negative...so, I don’t see the point in that. Because then the person will leave very quickly. There’s a lot of that. So, speaking to that sort of bit, if you like, speaking to that part of them that wants something different.” (Maria, Interview 2, pg. 11)*

*“...although in theory it’s the psychodynamic model, in practical terms I feel as if I’ve been made into something that’s quite concrete and am having to think of ways to explain things to him...which you wouldn’t do with a psychodynamic person. You’d just be able to think about the feeling...I explain a lot about emotions..... I change my style as much as I’m not very interpretative and I’m quite concrete. Yes, I do change my style, yeah.” (Agnes, Interview 1, pg 8-9)*

*“I mean, you know, we did a bit of education about trauma and how you carry stuff and it takes you back...uhmm...and gave her things about...you know, separating out...to get some understanding about what her reaction was to do with past experiences. ... it was like giving her a gift...to...to...to think about it in a different way.” (Helen, Interview 2, pg. 12)*

*“I think psychoanalytic work can, I know... working on the negative, but you also need to work on the positive...particularly for a vulnerable group... you know, you’ve to have a particular strength to always keep going on about the negative experiences, the negative everything... It’s the supportive element but also seeing the whole of you..” (Melanie, Interview 2, pg. 6)*

#### **2) Difficulty in accessing empathy**

*“Well, empathy is much more difficult when there are negative CT feelings...then, it depends on the degree of negative transference...uhmmm...” (Maria, Interview 2, pg. 9)*

*“I think the loss of empathy is the counter-transference reaction there, yeah.... I suppose because I wasn’t emphasising with him, I couldn’t be aware of what was going on for him. So, it was really a loss of connection. It was a real kind of broken connection there.” (Agnes, Interview 2, pg. 2)*

*“Well, I think it stifles all the potential creativity in fact... and I also believe that there are maybe...maybe phases when you’ve to just hold your breath and...little time...well, there’s no real empathy. You’ve to just hold your breath and hang on in there...uhmmm...in a way, that’s how relationships are, aren’t they? There are periods in any relationships, anywhere, where things are going really badly and do you walk out or do you hang in... in there and something on the edge softens and you can begin to work again.” (Helen, Interview 2, pg. 14)*

*“Uhhmm...but it was as if I couldn’t access... empathy towards that person at that point...for this patient. And then, after the supervisor, who could kind of just show me something that...different about him... I found myself able to shift out of that and start to get more... uhmm...” (Leah, Interview 1, pg. 16)*

*“I do have a lot of empathy with some clients, whereas often with others...say, you can’t feel anything for them and that’s...you know, you need to ally yourself with them, rather than against them.” (Melanie, Interview 2, pg. 19)*

### **3) Interpretations as unbearable**

*“I think some of the interpretations can be quite attacking, and I think they probably tend to be better off, because of the kind of...the weight of what’s going on...” (Maria, Interview 1, pg. 11)*

*“ Because they would find...they find interpretations so persecutory, I can not make interpretation... she simply can’t bear it. I never...sometimes I try an interpretation and she becomes like a toddler and he just says ‘No, no, no..’... suggesting that something is going on for her that’s intolerable.” (Agnes, Interview 1, pg. 5)*

*“I’m not somebody who, I think, gives a lot of interpretations anyway, but, yes, I think I... sometimes she uses them, she gobbles them up, as it were, and other times it’s absolutely the wrong time to do that.... Occasionally I think about these interpretations I do give...and she sometimes, she...it’s so helpful to her, well, it’s so helpful to her in the moment, because I probably give it to her not when she’s the most angry...uhmmm...so, what I don’t know is how much she can use those in those bad patches, but there’s certainly sometimes just the simplest thing that she’s never thought of or never looked at that way, I can’t think of an example, but...” (Helen, Interview 1, pg. 3 & pg. 17)*

*“I think it’s very threatening to...to be very here... and now sort of interpretations and so...I prefer to...when I am making sort of interpretations that I think would be quite shameful, quite exposing to somebody, I like to do it*



*later. I like to do it when we moved away from that moment...particularly with this sort of patient group....” (Maria, Interview 1, pg. 11)*

*“Yeah, yeah or just having, you know, some people...it can, you know, if you kind of... I feel accused of something that feels harsh, then the whole situation can change and they can then feel like I’m the attacker, I’m just critical...I don’t recognise their good sides, you know..” (Leah, Interview 2, Pg. 7)*

*“I wouldn’t...depending on what state they’re in on that day, I would challenge them accordingly...uhmmm..so, if they’re in a very vulnerable state, then I won’t...you know, I’ll kind of tone down a bit and will say it much more gently, whereas if they’re in a more robust mood that day, then I’ll...you know... be a bit more forthright, if you know what I’m saying.. because if you say really harsh to somebody...if you say something that can hurt somebody when they’re in a very vulnerable state, what’s that gonna do?...you’re gonna take it in a particular way...that your therapist thinks you’re this or that, you know, they’re not staying with you in that moment.” (Melanie, Interview 2, pg. 16)*

#### **4) Therapeutic relationship is threatening**

*“...I think the structure of the psychodynamic model helps them to connect... but I wouldn’t say it was a sort of full neurotic relationship. It’s... oh, yeah... and it might also be slightly misleading, because I think that actually the structure of the work may make it look as if they’ve got more of the relationship than they have.... But I think what you probably don’t feel...what I probably don’t feel is that you’re really sure of what I call the working alliance. In the same way that I might be with somebody who is healthier.” (Maria, Interview 1, pg. 3)*

*“It’s all about borderline, the kind of wanting the intimacy but also finding it too much. It’s kind of....it’s probably their fear and phobia of abandonment. If you get too close to somebody they get too close for you to feel overwhelmed, it’ll be too much or you can be completely terrified that they abandon you.” (Melanie, Interview 1, pg. 18)*

*“....it’s just having that connection feels intolerable because it’s such a reflection of her vulnerability and her hurt. I think saying that you are in pain it’s one thing, but having someone else saying it...it’s completely different. I don’t think she ever had that experience...she finds it very very hard.” (Agnes, Interview 2, pg. 5)*

*“In a way, I suppose, it needs to be possible to establish some kind of alliance and often with borderline patients, you also might need help from other parties involved in the case to help them get back to therapy. You can...you know, sometimes particularly, maybe more borderline...more disturbed patients...they might need some external help to get back to the therapeutic situation, because their capacity maybe to... to form an alliance is weak.” (Leah, Interview 2, pg. 3)*

*“...And to say that it makes me really sad, because normally she’s, I believe, she’s the most destructive when she is needy and vulnerable. And so, that’s the*

*way of pushing people away from connecting in a caring way to that part of her. ...she's so angry about her needy part and so wanting to be in denial about it, that vulnerable part....so, in a way, it also suits her that somebody does not come and care for the part that are intolerable to her."* (Helen, Interview 2, pg. 2)

#### **Master theme 4- Therapist omnipotence- 4 sub-themes**

##### **1) Power of therapist**

*"I suppose it's...it's trying to see if you can make enough incremental steps...that...that they make, you know...there's this sense of ...they may disappear for a while but you can kind of get back to it and things can refold sufficiently..."* (Maria, Interview 2, pg. 6)

*"And the thing, there's something about when these changes happen, they're extremely moving. That's what makes the work rewarding. That's why I also love doing this kind of work. It's not, you know... it's very demanding and difficult but sometimes you also then have moments, which really feel 'Well...I've really made... this process has really made a difference to someone's life'. Quite literally, sometimes I feel that this work saves people's lives. Uhmmm..."* (Leah, Interview 1, pg. 18)

*"...I don't think that he is ill and I think what he needs is psychotherapy and uhm... if he finds it quite difficult to stay in therapy and he is able to stay with me, I suppose...well, I haven't really thought this through, but I suppose I thought that I was... I was probably as much help as he was capable of receiving, uhm...because he is not ill."* (Agnes, Interview 1, pg. 16)

*"I think DBT is more behavioural, isn't it? Managing the...the...which is all very well, but... it didn't help her...she's still acting out...7 years she had the therapy and she'd still act out...and then she must have come to see me...and she's stopped acting out...she's much calmer now...and people are responding to her differently, you know..."* (Melanie, Interview 2, pg. 14)

*"I hope so.. (whispers and laughs)...I... I mean, she's already different...but she's different in a place that's quite scary, but she's much more in touch with her vulnerability, so I hope that wouldn't be the point where I left her.... I hope within that period of time she would have... she would have experienced a lot of things that are helpful to her and meaningful."* (Helen, Interview 2, pg. 16)

##### **2) Ability to survive the patient**

*"...because something is so destructive in borderline behaviour or in the borderline personality that it feels you're working against a great force... and I suppose if we're talking about it in Freudian terms, it's...it's the death instinct, isn't it? That's absolutely massive in the borderline pathology. And if we think about the death instinct as being something that wanted to break down connections... and the life instinct wants to create them, I think the borderline person lives largely in a kind of world of 80% destructiveness and 20%..."* (Maria, Interview 1, pg. 8)

*"I think she is doing something there to me which uhm...has been done to her. She's re-creating that situation and so to be so pushed to the edge that I can tolerate and find somewhere kind of surviving it and you know, that's really... and she'll come back in her much more thoughtful state of mind to the next session and say and apologise and thank me for having let her behave in this way and not to retaliate." (Leah, Interview 1, pg. 14)*

*"The difficult...the really difficult times are purely, for me, about me surviving, in order to have enough...well, first of all actually it's about me surviving, but then I want to try and get the relationship to survive as well. And I guess I need to survive first, in order to be able to...uhmm...I think there are times when my trying to contain her is probably secondary to me surviving myself. I think me surviving will contain her in some way." (Helen, Interview 2, pg. 6-7)*

*"I'm just in there with them but when I feel irritated I can feel myself tensing up in my shoulders and I can, you know... I always have to kind of readjust my position so that I can readjust myself back into the room as it were, if that makes sense. Because I can certainly feel it, I know I stop breathing and I can feel it usually... I'm sure they can feel it, am sure it changes the dynamics, but then I don't think it's always a bad thing for them to know they've an impact as well." (Melanie, Interview 1, pg. 19)*

*"I mean my...my previous supervisor used to say 'I don't know how you work with this man, I can't stand him'. She said 'I couldn't work with him, I don't know how you work with him. It's very interesting.'" (Agnes, Interview 1, pg. 25)*

### **3) Self-importance as therapist**

*"...I suppose what I feel is that I might represent that hope...the hope that is important... the hope that human experience is being something bigger and better than their experience of it to date.." (Maria, Interview 2, pg. 11)*

*"... But then, maybe it's not everyone, I think it might be me, although some of my colleagues, they care very much about their clients, and some of them just don't really... They're quite switched off...so, it just depends on the therapist really." (Melanie, Interview 2, pg. 10)*

*"...She feels, I think, when I am not there, when she, say, has a therapy break, she feels much more...uhmm...well, much less protected from these kind of more...when I'm not there, when she is not seeing me for a period, because of a break...sort of holiday...then I think she is more susceptible to feeling disturbed." (Leah, Interview 1, pg. 9)*

*"Yes, I think she does take me away with her...I think, yeah...yeah...and sometimes mostly that's in a positive way that I'm sure and given that during one of those weeks, there was almost daily email contact, you know, I was obviously under her skin as well in some way." (Helen, Interview 2, pg. 9)*

*"...He's had therapy before but he didn't like it and of course it would have been psychodynamic... strictly psychodynamic. ...The other therapist never said anything and he wants skills. And because I know about DBT...I can give him skills." (Agnes, Interview 2, pg. 10)*

#### **4) Capacity to contain the patient**

*"I think now...over the years...yes, I would probably.. I'm a bit more confident about being in...and really keeping things at a sort of fairly easy level about being containing...deliberately containing, closing things done and possibly even quite encouraging about what they can hang onto and what is...uhmm.." (Maria, Interview 1, pg. 14)*

*"I'm certainly trying to contain my feelings or to deny them... (laughs)...uhmm...I think there are times when my trying to contain hers is probably secondary to me surviving myself. I think me surviving will contain her in some way." (Helen, Interview 2, pg. 7)*

*"Mmm...well, I think if I couldn't take it in, I...I can't help, I mean, I might even harm...depends on what happens with the...just, I guess, push back the feelings...if I don't take it in, if I just push it back, I think...then I'm...well, I'm not being...what I'm doing is not therapeutic." (Leah, Interview 2, pg. 13)*

*"I feel enormous compassion in his struggle & since I've been seeing him I have really been holding it together while his life has collapsed... he has really been having it in a way, a breakdown. ...I.. my understanding is that if he hadn't been seeing me once a week, he could have gone off the rail." (Agnes, Interview 1, pg. 2)*

*"...I know how important that somebody can hold the despair... I think that's... that's... you know, for me, that's why I can connect with them." (Melanie, Interview 1, pg. 12)*

### **Master theme 5- Labelling as problematic- 4 sub-themes**

#### **1) BPD label is rejected by patients**

*"Some find it a very great problem and some patients spend a lot of their time in therapy and out of therapy, fighting the diagnosis... I remember one patient I saw in therapy not long ago, who had initially been given a diagnosis of bipolar disorder and then his...his psychiatrist he moved to started to question that diagnosis and said that he thought it was more BPD and then the patient disliked the diagnosis and was in constant dispute with his psychiatrist about that diagnosis and much preferred the bipolar diagnosis. I think there's something about the idea that a problem lies in your personality and it can't be kind of, in a way, located as...so easily as an illness that separate from your personality." (Leah, Interview 1, pg. 10)*

*"That's really interesting, because one of the issues for my client who has, as I said a lot of medical labels, is about being seen as...seen...what she actually...she obviously wants is the label not to exist.... To treat her as a human being...she wants to be a human being, she doesn't want to be other labels." (Helen, Interview 1, pg. 5)*

## 2) Label is helpful but unhelpful

*“Uhhmm... I think like all diagnostic tools, the DSM is not a tool unhelpful to visit... Like a theory, it's not at all unhelpful to visit it...regularly at various points...uhmm...we live in a very sort of over diagnosed age, don't we? So, it says quite a lot about it... the need and all that and it's quite debatable, isn't it? Half-pathologised (laughs) society...uhmm... so, holding that in mind, I think I would find it helpful to look at the DSM now and again, but I wouldn't necessary use it as a literal Bible.” (Maria, Interview 2, pg. 14)*

*“I'm not quite sure if you give somebody that label, what it means to them. You know...what...what...what they'd do with that label. I'd rather work with the person on...uhmm... what's going on for them and the meaning for them....bit I find the label useful in some ways and they might not find it useful... but there's something for me about giving somebody a label...I mean, you know, there's limited progress that can be made. I'm not sure how helpful it'd be in some way.” (Helen, Interview 1, pg. 4)*

*“At times I think it's helpful to have a category to put someone in, because it's useful to know where they're coming from, in away...to give you a bit more...something to start with. So, I find it helpful, because I can go and look at the books, to get a sense of, you know, not the diagnosis, just to refresh my mind that I'm working with borderlines.. in that sense it's helpful. In another sense, it's not helpful because BPD is a place where they place people they don't know where to place.. just to stick them in that category.” (Melanie, Interview 1, pg. 8)*

*“I think it's, you know, they...the DSM are useful descriptive guidelines, they describe a...uhmm...I mean if I look at them and I read them and I think 'Oh, yeah, that's a good description of the...uhm...kind of phenomena that we're dealing with here. But I don't object to them.” (Leah, Interview 1, pg. 12)*

*“They're constantly wrestling with horrible bad internal objects...and that's... that's how I really understand it psychoanalytically. So, in my...in my psychodynamic work I... I wouldn't ever think in terms of the DSM criteria, I just leave that to somebody else.” (Agnes, Interview 2, pg. 24)*

*“We're not particularly interested in giving them a diagnosis as such. I mean we...we talk to them about their experience...almost every day...in every session we're talking about that but...uhmm...yeah. (Leah, Interview 1, pg. 11)*

## 3) Questioning the validity of diagnosis

*“Uhhmm...we live in a very sort of over diagnosed age, don't we? So, it says quite a lot about it... the need and all that and it's quite debatable, isn't it?” (Maria, Interview 2, pg. 14)*

*“...the DSM criteria don't have that thing about.. they don't have a criteria for how you relate to other people, apart from having very intense, up and down, on and off relationships. ...he can't think about sort of getting to know people and being able to tolerate the things about them that might not be what he'd imagined he wants....so that doesn't really relate to the DSM and I think it's a*

*sort of borderline... a general borderline way of relating.” (Agnes, Interview 1, pg. 17)*

*“I think then it could be for, you know, anybody...teenagers could all become borderlines, if you say impulsive behaviour and all that...uhmm...but I don’t think it was based on that list...I think it was based much more...uhmm...on the internal relationship that they’ve with themselves. I think it was based much more on that...it was a much kind of...deeper...deep examination rather than just looking at the criteria.” (Melanie, Interview 2, pg. 21)*

*“I suppose I think all people have personality disorders and that’s all a matter of degree. I don’t think I’m fundamentally different... I... I don’t have a diagnosis of BPD and I don’t think I have one, ...but at the same time I don’t think I am fundamentally different and I suppose, it is something about the psychoanalytic way of thinking, which basically assumes that we’re all patients....and that there are ways, in which our personalities don’t function as well as they could. And I.. that I can...that we can be helped to function better...or understand ourselves better...or incorporate aspects of ourselves, you know, learn and change and develop...uhmm..” (Leah, Interview 1, pg. 11)*

#### **4) Label reinforces psychopathology**

*“I think it’s been a damaging term...uhmmm...that has been used, because people don’t always take the responsibility then, so, I think some of the borderline personality, you can almost say ‘Well, oh, well... it’s not me... it’s not me...’” (Melanie, Interview 2, pg. 13)*

*“I think that was more from my sociological background, my concerns about people being given labels and then only seeing through that label becomes a sort of self-fulfilling prophecy, you know, once you are seen that way, you get treated in that way and it can be a negative spiral, very hard for somebody to get to be put...for people in society, as it were, to get out of it.” (Helen, Interview 1, pg. 2)*

*“...I just think it sounds really bad and I couldn’t imagine telling a client what I thought... that’s what they had, they might find it quite helpful but I couldn’t imagine telling this client that she had it, because she’d be devastated, I think. ... I couldn’t imagine ever telling her that.” (Agnes, Interview 2, pg. 25)*

*“That’s why I talk about that because I feel that ...that’s a danger of thinking about things too much, in terms of the diagnosis rather than the person and the experience... and our assessment of how they respond to an approach, which is more psychoanalytic approach, which is about helping them think about themselves and what happens when they encounter another person.” (Leah, Interview 1, pg.13)*

## *Appendix 9*

### **Interview 1 - transcript extract.**

**ABCD1238 9 (Helen)**

*I 1: Could you please tell me if you've got a client who's got a condition called BPD at the moment?*

**H 1:** I am working with someone who didn't come to me with that diagnosis or label, partly because it was a self-referral, but as I've talked about her in supervision, that's the label that people feel that clearly fits. And as I learnt on the training course about it, it feels that there is enough to think that...that's...I'm not into labelling myself, but I guess it helps me to prepare myself and how I work with this person, which is not radically different from how I work with other clients, but there are some things that I do differently. Uhmm... and I think for me my training was actually having very...very firm boundaries & with this client I've...I've that clear framework but I am a little more flexible in that & it feels or it felt necessary I...I wouldn't have held the client if I hadn't really acknowledged particular needs that she has but I try to be very, very careful that I'm still really grounded.

*I 2: I understand that you and your supervisor agreed that this client has certain features of BPD...uhmm...what does this mean for you as a PT, this term...BPD?*

**H 2:** I think what it means for me is that something goes on in me that I...isn't, isn't how I normally am. I guess at the extreme it's something it gets completely under my skin and inside me...there's an intensity of need and demanding that I don't experience with other clients. And, yes...I guess a sort of vulnerability in myself that... and it's hard for me to know whether some of the other facts about this client...where borderline ends and where this is a fact that is outside but (indecipherable) central to know is hard to know really.

*I 3: Did you use something to identify it?*

**H 3:** I didn't, no, I've a couple of supervisors and it was interesting that both came up almost immediately with this. And I think it was an intensity of rage...uhmm...that might've been one of the key factors. Not my rage actually, but then...yeah, not my rage at that point. Yes.

*I 4: You've mentioned that you are not into labelling yourself and I find that interesting.*

**H 4:** Yeah. Well, I think that comes more from a sociology...I was a social worker originally, and I think that was more from that sociological background, my concerns about people being given labels and then only seeing through that label becomes a sort of self-fulfilling prophecy, you know, once you've seen that way, you get treated in that way and it can be a negative spiral, very hard for somebody to get to be put...for people in society, as it were, to get out of it. So, uhmm...although having said that, I'm saying that I find it quite helpful in this

instance. Although, yeah, I was interested, on the training, to see how much similarity or differencing the client that I see.

*I 5: So, what I understand is that outside the room, in the real world it can be really detrimental...*

**H 5:** Oh, yes, absolutely.

*I 6: ... for the client to have a label, but in therapy it could actually be helpful, because you know where you stand or you understand...*

**H 6:** Well, I think...because I guess I felt totally at sea, I think that it may've given me something to relate to...to help me understand. I guess it pointed me in a direction of some theories and things that have helped me to see things. I mean coming on that 2-days training was like "Oh, Gosh, yes, I really want to go and do this". And then I met other people who were describing their experiences that made me feel like I wasn't alone and it wasn't all me, being inadequate. So...

**I 7:** So, this feeling of not being adequate, is this something typical that you find you have?

**H 7:** Oh, yeah. Yes. (Laughs).

*I 8: I wonder why that is that you feel like that.*

**H 8:** Oh, because somebody feels...when things go well with a client, think that I've done fantastically and when things go bad I think that I've not done fantastically. So, it's hard to focus only on the things that have gone well, that I'm a part of and only focus on the things where there's a problem, which feels very difficult and I take responsibility for that. But that, that's me.

*I 9: Do you find it more difficult with this specific client?*

**H 9:** Well, now...in a way, I don't. And in a way, I think that I...I think I practise in a slightly difficult way. Now, probably, it's how it'd be good for me to practise all the time. Ummm...but there's something with this client that has...at some level I've let go of "I must get it right and do it". You know, I must come up with the interpretation that's going to change...I very much just sit and sometimes I do reflect back. So, I...for me, it's really...I don't really try to change anything, I just try to be with. Which is what we're meant to do as therapists all the time, but often there's a different dynamic between me and different clients I've had.

*I 10: Is this the first time that you've somebody with...*

**H 10:** I think so.

*I 11: So, this is a very different experience for you.*

**H 11:** It does feel different.



*I 12: And you've mentioned that you've changed the way you practice...*

**H 12:** Well, I think I'm much more, you know, coming into the room and just really sort of try and be with this person in a...in a more conscious way than perhaps with other clients.

*I 13: It sounds effortful. Do you do something differently?*

**H 13:** Uhhh...I avoid giving interpretations. I'm not somebody, who I think, gives a lot of interpretations anyway, but, I think I... sometimes she uses them, she gobbles them up, as if it were and other times it's absolutely the wrong time to do that. It's also somebody who've never had therapy before. So, which I think is interesting, you know what I mean. Because I can imagine a lot of psychotherapists might get a client who's been through many many times.

*I 14: Yes, I understand. Uhhh.. we've been talking about labelling...*

**H 14:** Yes.

*I 15: ...just to explore that a little further. How do you feel about it?*

**H 15:** I can't talk in general terms about that.,,

*I 16: When it comes to your experience.*

**H 16:** Yeah. I...I want to say, I think it would not be helpful labelling clients at all, quite the opposite, but I'm thinking about why I'm saying that. Uhhh... and I'm not sure why I'm saying it, but my sense is that it...I think it's because I am not quite sure if you give somebody that label, what it means to them. You know...what...what...what they'd do with that label. I'd rather work with the person on...uhmm...what's going on for them and the meaning for them. I mean, it's interesting, as I can hear myself saying that, but I find the label useful in some ways and they might not find it useful, but there's something for me about giving somebody a label...I don't know if it's general of this person, or how I'd feel if I was given a label, I don't know that... And...and...sort of saying, "So, so, now I've got the label, what do I do with it?". I mean, you know, there's limited progress that can be made. I'm not sure how helpful it'd be in some way.

*I 17: Yes, I just wonder whether you've ever discussed with this specific client how you feel about what she might have.*

**H 17:** Yeah. I talk with her about...I do, about how she feels or how she behaves in situations, but I don't and how that is for her and her experience of the world that she plays a part in that, obviously she does, what part she plays in that. But I...I think...I don't want to talk too much about her in detail, but she has a number of medical labels, which she can do nothing about and feels absolutely powerless in itself...that's an enormous feature of our work. So, I don't think giving her another label she can't do anything about would be helpful at all at the

moment. And I suppose, I'm sort of feeling I haven't had enough borderline personality to know whether this is always the case, you know. It's a helpful label and yet I don't want to burden her with it. I want to keep some sort of open mind as well, if that makes sense. Because am worried that I would...everything would be seen through that label and somehow I'd miss...miss important things about her, while being with her in a different sort of way than I am at the moment. And I...you know, I've experienced the rage or the hate...uhmm...but not for a little while, so although I'm not getting back into something sweet and lightness...I want her & I to be able to...I want to enjoy this phase we're in, knowing that something else, no doubt, it's gonna happen...uhmm and I want to build on positives that are going on in the room for a while. I want to take those in and hopefully, let's see whether I should be able to hold when you know something that spots off the rage.

*I 18: So, as I understand, what you're saying is that you're rather being with the human being and relate to the human being than treat the symptoms of the diagnosis or to treat the label...*

**H 18:** Or to treat the label...Am happy to look at the symptoms as they manifest themselves in the room, yeah. That's really interesting, because one of the issues for my client who has, as I said a lot of medical labels, is about being seen as...seen...what she actually, she obviously wants is the label not to exist. There's something about you said...to treat her as a human being...she wants to be a human being, she doesn't want to be these other labels.

*I 19: And...do I understand this right when you said that you might be with her differently if she had a label?*

**H 19:** I suppose,...I can't give you an example of how that might be, but I suppose, I want to...I want the symptoms of that label. I don't want to deny them and I want to work with them but I don't want them to become everything. And I guess I'm concerned if that label is in the centre of the room...then it would. And that, as I said, maybe because of other things in her life.

*I 20: How easy do you find it to relate to her when you work with her?*

**H 20:** Uhhh...I...it's a mixture...I...she's very upfront, very...says...says exactly what she wants to say, but sometimes she finds it really difficult to do, if you know what I mean, but it's...it's a combination of walking on eggshells and really enjoying the challenge of working with her. Because there is something so present about her...so, I don't know, I just...she's...she's in some ways, she's quite naïve about it all, I suppose. So, in some ways, she's quite disinhibited in what she says. Uhhh...

*I 21: So, it sounds like she can be very different through your work.*

**H 21:** Yeah. Uhhh...she is... she can be very... very angry or incredibly vulnerable and sad. Well, it's hard...it's something new she is learning to face in herself...how...anger has been a defence...anger and humour and you know the word 'feisty', yes...very...that's how she likes to see herself.

*I 22: Mmm... and how does that make you feel when in the therapy relationship the client is more angry?*

**H 22:** Well, I don't like it, but it's happening, but it...uhmm...if I can survive it, then it gives us some really good material and she's becoming much much more aware that...that's covering up something else and she's more able to be with that...to stay with that.

**I 23:** *Would you be able to describe certain feelings you have when you are in that situation when the client's angry?*

**H 23:** I feel...uhmm...well, I think I go numb, actually...in the sense of protecting myself...I...yes, yes...I am receiving the gunshots but I'm also rendered sort of speechless...don't know what to say...uhmm...so, I just, I try and not express anger with her, I try not to retort, but I think for me, it's...I always go into my 'I need to survive' mode. Uhmm...

**I 24:** *How do you deal with that feeling in the session?*

**H 24:** Well, in the session, I think, part of me steps out, probably out of the room... and it's slightly like holding my breath...or...for the entire session. And probably what I also try and do is...uhmm...I want to say 'replicate' her, because I don't want her to, it's usually within that sort of fret of her not coming back, when I want to hold her sufficiency to...not to let that be a decision that is final. In that...in the room...so, I guess I tentatively try to reach out. What I don't, what I don't do, what I'm not able to do, what I haven't been able to do when that...there's guns of losing...is to stay with and remember that this is coming from an utter, utter vulnerability and fragility. And I don't know whether somehow interpreting that, at that time I suspect it'd only add fuel to the fire, I don't know.

**I 25:** *So, it sounds like you've never actually tried...*

**H 25:** I haven't. I've had 2 or 3 sessions when it's been as I've described. What I'm more able to do now is, usually at the end of the session, when a sort of dissatisfaction or anger or demand occurs, I'm more able to say 'I know it's really difficult finishing sessions and things'. I contain her. And that on the whole has kept it calmer.

**I 26:** *It's the containment that...*

**P 26:** In a sense that...it hasn't got out of hand enough for ...in her...for her not...so that she can, I think, feel a little bit understood and heard.

**I 27:** *Mmm...so somebody can...*

**P 27:** Somebody can see through this...beginnings and anger and sarcasm and joke or demanding reassurance.

**I 28:** *...and relate to her vulnerable sides...*

**P 28:** ...and that it's ok.

**I 29:** *... the relationship is very important when you are with this client.*

**P 29:** Yes, it is. Yeah, yeah, yeah.

**I 30:** *For her as well.*

**P 30:** Absolutely...absolutely.

